

MEDICARE'S REGULATORY BURDEN ON PROVIDERS

THURSDAY, MAY 18, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
TASK FORCE ON HEALTH,
Washington, DC.

The Task Force met, pursuant to call, at 10:15 a.m. in room 210, Cannon House Office Building, Hon. Saxby Chambliss (chairman of the Task Force) presiding.

Members present: Representatives Chambliss, Fletcher, Gutknecht, Spratt, McDermott, and Lucas.

Chairman CHAMBLISS. We can come to order here and we will go ahead and begin our hearing. Let me just say that I am very pleased to see this number of folks here because there is no more important issue, in my opinion, that the Budget Committee can carry out than its function of oversight, particularly in the area of waste, fraud, and abuse in the Federal Government.

Let me also say that we are not here to throw stones and throw darts at anybody. Instead our purpose in this is going to be is, at least as far as the Health Care Task Force is concerned, is to try to find the deficiencies in the system, try to find the areas where the health care delivery system from a Federal perspective is not working the way that it was intended to work, or as Congress envisioned it to work. We also expect to find some areas that we can make recommendations either to the Appropriations Committee or to the government agencies that are responsible for the health care aspect of the Federal Government to not only improve the system but also to save money. And if we can do that, then I think we will accomplish an awful lot and I certainly hope that that goal is going to be achieved.

I have a statement for the record that I am going to submit, and I don't want to sit here and read all of that statement but let me just say that first of all, I appreciate our witnesses being here today. Dr. Robinson, Ms. Murray, Mr. Vaughan, we are very appreciative of you all for giving your time and lending your talents to the exercise that we are going to be carrying out. I can't introduce the panel without looking at my good friend, Joe Sam Robinson, who I have known for many years and who is not just an excellent individual but he is a great American, and he is somebody who cares about not just good delivery of health care but cares about the way the system operates. And I am confident that our other two witnesses feel that same way and that this is going to be a very beneficial hearing this morning.

[The prepared statement of Saxby Chambliss follows:]

PREPARED STATEMENT OF HON. SAXBY CHAMBLISS, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF GEORGIA

As part of a comprehensive effort in the House of Representatives to provide increased oversight and scrutiny of how our tax dollars are spent in Washington and how those decisions effect the daily lives of all Americans, the House Budget Committee recently created six bipartisan task forces to investigate instances of waste, fraud, abuse, and mismanagement in Federal programs.

Specifically, the Health Task Force will examine issues reaching across all health-related accounts of the Federal budget. Today, we turn our attention to the waste of resources associated with the burdens that Medicare's complex regulatory system imposes on the health care community and the patients they serve. Such attention may be appropriate, as a college professor was recently quoted in the Wall Street Journal as saying that the statutes and rules governing Medicare * * * now run the risk of becoming themselves a form of waste, fraud, and abuse.

While I want to ensure this Task Force's focus remains on eliminating wasteful Federal programs or practices and identifying illegitimate and fraudulent actors stealing taxpayer dollars, it is equally important that America's program for providing seniors' healthcare does not penalize honest providers struggling to comply with and meet the frustrating bureaucratic maze of Federal health care regulations.

Currently, there is no comprehensive estimate of the regulatory burdens and costs imposed on providers by the Medicare Program, resulting from either laws passed by Congress or regulations implemented by the Health Care Financing Administration (HCFA). In an effort to determine the depth of this problem, last year in the Balanced Budget Refinement Act, Congress required the Medicare Payment Advisory Committee (MedPAC) to conduct "a study on the complexity of the Medicare Program and the levels of burdens placed on providers through Federal regulations. While the MedPAC report isn't due until December 2001, forums such as this one can offer illustrations of the impact of Medicare regulations in the real world of medicine.

Although much of the evidence of Medicare's regulatory burden on providers is anecdotal, it is known that providers must comply with almost 111,000 pages of Medicare regulations and supporting documents. According to the Heritage Foundation, this is roughly six times the size of the impossibly complex Internal Revenue Service code and its Federal tax regulations.

In fact, before coming to Washington this week, one of our witnesses, Dr. Joe Sam Robinson, actually weighed the amount of HCFA regulations his practice receives every year. The result: a whopping 35 pounds of regulations arrive in his office each year!

The purpose of today's hearing is to hear firsthand testimony from individuals such as Dr. Robinson on how those 35 pounds of new regulations each year, as well as the existing ones, effect his ability to provide care to his patients. After all, if the billions of tax dollars spent each year on the worthwhile Medicare Program are not meeting the needs of the taxpayers the program was designed to benefit, a real problem exists.

We will also hear today that the problem at 'ground zero' in healthcare delivery is not isolated to the content of regulations emanating from Washington. Ms. Kathleen Murray will offer testimony regarding the morass of duplicative and counter-productive healthcare regulations that exist among 29 different Federal organizations, ranging from the Internal Revenue Service to the Occupational Safety and Health Administration (OSHA) to the Environmental Protection Agency (EPA).

While we will no doubt hear compelling testimony from the witnesses before the Health Task Force today, it has become clear that they are not the lone voices in the wilderness on the complexity and burdensome nature of Medicare. In just a few short months my office has heard from numerous providers in Georgia alone about the burden of Medicare regulations on their ability to provide care. I would like to share just a few of those examples at this time.

Before citing one specific burdensome example, I would like to share the comments of an e-mail I recently received from a constituent on this matter that seems to succinctly sum up sentiment on this issue in Georgia:

Dear Sir:

I got out of medicine recently because I couldn't take the government interference any more—and it is much worse now. My colleagues tell me I better be glad I got out when I did. How sad—we go to school for years and then cannot practice medicine and provide care for people because we spend

so much time and money complying with frustrating bureaucratic regulations. It's a crying shame.

Retired physician,
Macon, GA.

A major regulatory headache commonly cited that constantly frustrates hospital providers and annoys Medicare beneficiaries is the Medicare Secondary Payer Questionnaire (MSPQ). The purpose of the MSPQ is sound as it is to ensure that Medicare does not pay for services that another payer is responsible for (e.g. auto insurance covering injuries sustained in auto accident). However, in practice, the MSPQ has become an unnecessarily complex and unreasonable approach to determining whether or not there is another payer that should be primary.

Two examples underlie the problems of the MSPQ. One, is its duplicative and repetitive nature because HCFA requires the MSPQ to be completed on each encounter, regardless of the service provided. Given that many Medicare beneficiaries often suffer from chronic illnesses that require ongoing diagnostic monitoring and treatment, recurring patients must answer MSPQ questions on a weekly, or even a daily, basis. As one can imagine, this is quite frustrating to a beneficiary who does not understand why the hospital must ask the same questions it did only a week ago—questions that generally take anywhere from 30 to 40 minutes to process and answer. Not only is it frustrating to the beneficiary, but it is an unnecessary waste of the provider's resources to waste valuable staff time that could be better spent attending to other patients' needs.

A second problem with the MSPQ is the information it requires the provider to seek. For example, the beneficiary's retirement date must be included. According to Georgia providers, patients are often elderly, sick, and/or confused and cannot remember their retirement date. Their fiscal intermediary has instructed hospitals in Georgia that in those cases, they should get the information from a family member. If a family member isn't available, they are to contact the beneficiary's previous employer to get the retirement date. Sometimes, these beneficiaries have been retired for 25 years or more, and the employer may not even be in business, or be in another state. How nonsensical is it for hospital employees to spend their time tracking down former employers across the nation. Such a policy is not only unnecessarily time consuming, but it borders on an invasion of privacy and causes concern and potential embarrassment for all involved.

The above example is but one of many my office has received detailing the complexity and burdensome nature of Medicare. The bottom line is whether both the American taxpayer and Medicare beneficiaries are getting the best bang for their buck when it comes to Medicare and the regulations that govern its implementation.

Not only do I look forward to testimony from our witnesses who engage in the health care arena on a daily basis, but I look forward to a follow-up hearing in which various administrative agencies will have an opportunity to respond to comments made today as well as answer questions from Members of this panel on how their regulatory structure best meets the needs of beneficiaries and taxpayers.

Chairman CHAMBLISS. I want to take an opportunity to let my friend, Mr. McDermott, as well as Mr. Spratt make any opening remarks that they would like to make this morning.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to thank you for having this hearing today to discuss Medicare's regulatory burden on providers. I look forward to really working on this issue because I am one of those people who believes that Medicare is a good program. I think it is an enormous benefit for the country and for the elderly in this country, and I will always be interested in hearing ways in which we can improve the program.

I hope that today's testimony will be more than just telling us all the problems with Medicare, but you will also have suggestions about ways in which the program can be improved. I sit on the Ways and Means Committee and I am on the Health Subcommittee that has jurisdiction over Medicare and I know a good bit about it. Also, being a physician, I have experienced lots of things as a provider and recently having been a patient, I understand a little bit about the reimbursement system that goes on in this country in the private sector.

Medicare's error rate has been cut in half over the past few years and I think we will hope to hear ways in which we can make it be even better. But one of the problems I see—and this committee hearing is interesting to me because on the one hand we want to cut waste, fraud, and abuse. Everybody agrees to that. There isn't anybody in the Congress, all 435 Members, who would say, I want there to be more waste, fraud, and abuse out there. So we always say we want to cut it. And we write bills, some of which I voted against, like the balanced budget amendments in 1997, because I knew what it would do to Medicare. And we write all kinds of regulations as an outgrowth of the bills that we pass.

These regulations don't come from God or from the sky. They come from the Congress, through the regulatory process. And sometimes we get, when Murphy's law takes over, something we did not really intend. So I hope that we can hear about that.

But what troubles me in looking at the appropriations process this year is that the 2001 budget is 6 percent less than it was last year. That is a real cut of \$127 million, and \$220 million below the President's request. Now, if you are serious about finding waste, fraud, and abuse you have to look for it, and you won't take away HCFA's people and money and expect it to happen. I think that that is one of the problems we really have in looking at this whole issue.

The second one is that HCFA is the largest health insurer in the Nation. We cover 74 million Americans through Medicare, Medicaid and the children's—the CHIP program, the health program for children. And we are spending \$368 billion of taxpayers' money. So we have a responsibility to be sure that it is spent adequately and effectively for good health care. It is not an easy process to run something like that. We have delegated it to private insurance companies.

Having been a physician and having had to deal with private insurance companies as well as Medicare, I find it hard to see that Medicare is any worse than dealing with the private insurers. So I would like to hear in your testimony whatever you have to say about how the private sector does it better than the government does it, using private sector intermediaries.

I think that it is easy to rant and rave about the problems, but having been in the medical profession since 1968, I know enough about what goes on in the private sector to know that that is not without its problems also. I had an aortic valve replaced and I was sitting at home, and you are recovering from something like that, you have nothing to do but go and get the mail. So I get the mail and look at all these bills and here comes a bill for a consultant who saw me and they denied the payment. So I picked up the phone and called and said, "why you are denying the payment?" They said, "well, we have no record that you were in the hospital." And I said, "well, I don't know where you think they did the aortic valve replacement—in the parking lot?" They said, "well, the hospital hasn't sent in their report yet, so as soon as they send in their report we will resubmit the bill on the doctor's consultation record."

Now, the waste in the health care system is, I think, on both sides and I want to hear—because I know that some of the intermediaries are taking the regulations of HCFA and using them. And

so I see some real problems here and I am really eager to hear what people have to say about how we can improve or simplify and still guarantee to the American public that we have looked at where their money is going. Because there is certainly money in the system that is not being well spent, and I think no one who looks at the system would say that it is otherwise. It is the same in the defense industry or in a lot of other major expenditure areas of the United States Government. And I think we need to be mindful that we have to find it, but how can we do it in a less burdensome way? I think we are all open to hear. So I look forward to this testimony and I ask unanimous consent to put my whole statement in the record.

Chairman CHAMBLISS. Without objection.

[The prepared statement of Jim McDermott follows:]

PREPARED STATEMENT OF HON. JIM MCDERMOTT, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF WASHINGTON

Chairman Chambliss, thank you for having this hearing today to discuss Medicare's regulatory burden on providers. I look forward to working with you and other members of the Health Task Force to address the challenges facing Medicare, which will celebrate its 35th birthday this year. I believe we share the goals of improving the program's level of efficiency while ensuring access to high-quality and accessible services for all beneficiaries. We may not always agree on how to achieve those goals, but I do think we share the same ultimate goals.

When Chairman Kasich created these Task Forces on Fraud, Waste, and Abuse, the stated purpose for their creation was to enable Congress to have greater oversight to prevent and detect fraud, waste, and abuse. I am sympathetic to the concerns of legitimate providers who believe they are burdened by Medicare's regulations, but I am not sure how these concerns fit the purpose of the Task Forces. Medicare's error rate has been cut in half over the past few years. I hope we will hear how we can help the agency responsible for administering Medicare, the Health Care Financing Administration (HCFA), keep reducing the error rate while we diminish the burden on legitimate providers.

Because Medicare is so important to the 39 million seniors and disabled persons who rely on it to provide health care coverage, I look forward to hearing from our witnesses today. I hope they will provide us with clear examples from the private sector or other government programs for improving Medicare without jeopardizing efforts to provide quality care for seniors. I hope the models they provide will allow us to strengthen our efforts to prevent and detect fraud, waste, and abuse by unscrupulous providers without impeding the care provided by legitimate health care providers.

Medicare is an exceedingly complex program and its administration is complex. According to recent congressional testimony by the Administrator of the Health Care Financing Administration (HCFA), Nancy-Ann DeParle, HCFA "contracts with 55 private health insurers to process nearly 1 billion Medicare fee-for-service claims each year, and with 346 private health plans that provide managed care. For Medicare alone, the agency pays more than \$210 billion in claims to some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year. HCFA is the largest health insurer in the nation, providing coverage for some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program, and paying about \$368 billion for health care services this year."

The statutory language related to all HCFA programs, not just Medicare, encompasses 900 pages. HCFA's implementing regulations encompass 1,700 pages. However, it is not the number of statutes or the number of regulations that should guide us. We want the programs to be effective and regulated effectively. Undoubtedly, there are areas that could be clarified and strengthened to make it easier for legitimate providers to document legitimate claims for timely payment. We do not want to punish the legitimate provider.

During the last 3 years, significant improvements were made in reducing Medicare's improper payment rate. Between 1996 and 1998, the error rate was cut almost in half (a 45 percent reduction). Medicare's payment error rate declined from 14 percent to 7.97 percent. However, the amount of payment errors is still too high (about \$13 billion annually). HCFA is ahead of its Government Performance Review Act goal of 9 percent by 1999 and is committed to its strategy to again cut the pay-

ment error rate in about half and reduce it to 5 percent by 2002. Clearly, reduction of these payment errors, protection of the integrity of the Medicare Trust Fund, provision of appropriate coverage to beneficiaries, and provision of appropriate payment to providers are daunting tasks. I hope our witnesses can give us their insights as to how we can achieve all of the goals.

I think the testimony we receive today can give us a preview of what we might expect when MedPAC completes the study Congress required in the Balanced Budget Refinement Act (BBRA) of 1999. This comprehensive review of all providers and recommendations for simplification of many of Medicare's complexities will be available to us by December 31, 2001. In the meantime, today's testimony will shine some light on these areas for us to consider.

I look forward to hearing from all of you. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Mr. Spratt.

Mr. SPRATT. Mr. Chairman, I thank you for calling the hearing and I really think that oversight is the second most important function of this committee, and I am glad to see us undertaking it particularly in this area.

I simply want to speak—to welcome one of my former constituents. When we invited him, I think he was my constituent, but he is now in your constituency, Mr. Chairman—Page Vaughan, who was with the Carolina Pines Hospital, a brand-new hospital in Hartsville, SC, and now is in Statesboro, GA. His parent firm is Health Management Associates. He comes here to bring a point of view that I think we need to hear.

We need to talk to HCFA about the administration of these programs but we also need to talk to those hospitals who are on the receiving end—and in this particular case, a hospital in small town to rural area setting—about the particular problems they face. So, Page, we are glad that you are here. We appreciate you coming.

Chairman CHAMBLISS. Thank you, Mr. Spratt. Does any other member wish to make a statement?

Mr. GUTKNECHT. I promise to be brief. I would agree that I think this is an area where we need more congressional oversight. I think every Member who spends any time in their district visiting with people in the health care delivery system recognizes that this system has become so clumsy and so burdensome that sometimes it seems as if the system consumes the participants. Using the good doctor's own numbers if they are correct, and I believe they are, we are spending approximately \$5,000 per person on Medicare and Medicaid coverage. And if you talk to the providers, they are hard-pressed to see that they get that in kinds of benefits from the amount of money that we spend.

I hear from my nursing homes, I hear from my hospitals, I hear from providers of all kinds, home health care, that the paperwork and the nitpicking that goes on is just unbearable. And it seems to me that we must find a simpler system for the providers so that we continue to be able to take care of the people who need the help; but at the same time, we don't continue to reinforce what I believe is one of the unwritten rules of Washington, and that is that no good deed goes unpunished. The providers that are doing a good job should not continually be held up as criminals. While we want to stop waste, fraud, and abuse, I think that there has got to be some kind of a happy medium. So I appreciate this hearing and I look forward to the testimony.

Chairman CHAMBLISS. Thank you, sir. Mr. Lucas.

Mr. LUCAS. Mr. Chairman, I am looking forward to the hearing today to see what we might do to improve our system. I am very open and hopeful that today will be very constructive.

Chairman CHAMBLISS. Great. Just for the sake of scheduling, let me tell our members as well as our witnesses that we are going to have a series of votes beginning somewhere around 10:45. We are going to have a break at that point in time to go vote and come back and resume our hearing. I think we will have time to get through at least our opening statements. And we will ask your patience through this process as there are times when we have to go do what we get paid to do, which is to carry out the legislative business of the country.

I will tell our witnesses, also by way of schedule, that our next hearing is going to be in a couple of weeks and the witnesses at that hearing will be the folks from Medicare, from HCFA, from the payer side, who are going to come in and explain from their perspective how the system is working. And if there are things that this panel thinks that we particularly need to be on the lookout for, we need to have responsive questions or responsive answers on, it would be important to us to know that so that as we go into that next phase we are prepared for that.

We are now joined by the vice chairman of the Task Force, Dr. Fletcher. Other members have given their statements. If you have anything you want to say before we begin we will be glad to hear from you.

Mr. FLETCHER. Thank you, Mr. Chairman. I appreciate you holding these hearings. I think it is very important. You know, I met with a physician yesterday and we were discussing HCFA and some of the oversight, and one of the concerns was raised in that meeting of the fact that sometimes the way HCFA implements fraud and abuse and other regulations, certainly impairs I think sometimes a provider's ability to really provide the care and encumbers them with a great deal of bureaucracy. And sometimes I am not sure we are targeted as well on fraud and abuse.

So I think it is going to be an excellent opportunity to oversee the actions of HCFA and to make sure that we work to provide better health care for all of our constituents. Thank you, Mr. Chairman.

Chairman CHAMBLISS. Thank you, Dr. Fletcher. We will begin the testimony and, Dr. Robinson, we will go to you, go to Ms. Murray, then Mr. Vaughan.

**STATEMENT OF JOE SAM ROBINSON, JR., M.D., PRESIDENT,
THE NEUROLOGICAL INSTITUTE OF CENTRAL GEORGIA,
MACON, GA**

Dr. ROBINSON. Thank you, Mr. Chambliss. Good morning. My name is Joe Sam Robinson and I am a practicing neurosurgeon from the beautiful city of Macon, GA. And I would like to say I am honored to be here today to discuss some of these issues; more exactly, the impact that HCFA regulation has upon practicing physicians and, more importantly, upon their patients.

I think there are two general comments I would like to make before I get started. The first one is that I think practicing physicians basically respect HCFA and the task that it has been charged with

performing. It is a very complicated situation. We have an aging population. There is an increasing technology, evolving technology, that these patients need access to, and their budgetary restraints. So it is natural there is going to be some tension and conflict in this realm. So I can appreciate that.

The next issue I would like to just make reference to is the spirit of my remarks are going to be as much nonpartisan as I can make them. And I think one of the difficulties that happens, and I think physicians are upset about this, is they see issues involving health care being politicized and the differing parties attempting to gain some leverage for one reason or another. And I just think health care is too important to let this happen. So we shouldn't be in that domain.

I have five random comments I would like to make just from my point as sort of a ground zero of the health care delivery system. I don't have any special expertise in a lot of the bureaucratic issues involved here but I can make some remarks about how some of these regulations have impacted upon my patients and the health care delivery system.

My first comment is the HCFA regulations are excessively complicated, voluminous, and changeable. They are just absolutely amazing. I asked my office manager to bring in the documents we had received from HCFA in the past year or so, so I could look them over. And she came into my office, I was concerned she might get a little low back injury; might have a Workmen's Compensation problem on our hands because they were so heavy.

So rather than going through them, I had them weighed, and she reported back to me they weighed 35 pounds. So 35 pounds of regulations have come upon our small practice in Macon, GA, from HCFA in the course of a year. And as a practicing physician, I am responsible for making sure those regulations are effectuated. There are all kinds of nuances about patient care documentation, and what happens is it is just impossible for me to do that. It is just past my abilities. So I have to depend on people in my office to make sure these regulations are complied with and I am responsible for those, for the compliance with these incredible regulations.

So what that means is I am always nervous, and as far as I know all the other health care providers I know are nervous that they may not be in compliance with these regulations, and that is not a good situation.

Which brings me to my second point, which is the sense of intimidation and fear which HCFA has fostered among physicians. It is a very troubling situation. When I came to Washington, to the big city from our beautiful, bucolic town of Macon, GA, people warned me, my God, you are going up there? The black helicopter may come after you if you speak against HCFA. It is very dangerous what might happen. And this is a very, to me, upsetting situation. And I think there is—I have to say that regrettably this is part, in my opinion, of HCFA's policies.

I have got something that actually came off the HCFA Web site, it is dated March 17, 1998, and they are talking about fraud and abuse in there. And it is—one of their purposes is to encourage a fear of prosecution and punishment for unscrupulous providers. Well, I don't know any unscrupulous providers, but I do know plen-

ty of doctors that are nervous that their office staff has complied with these complicated regulations. And some of the things HCFA does or they suggest doing in this Web site are, number one, to publicize the punishments to achieve a sentinel effect. Need to create a fear of being detected. Random on-site aggressive reviews. Number three, well-focused random reviews and audits. And number four, unannounced auditor visits.

So this is sort of the spirit with which HCFA is approaching the 500,000 physicians in the country that ought to be their natural allies in administering this program. So it is not a good way to start things going.

The third comment I'd like to make is that there is a lot of evolving, changing technology out there, and it is particularly present in neurosurgery, and that it is important for the elder citizens of this country to have access to that technology. So it is particularly important that HCFA doesn't hinder their access. And I know of several examples when that basically happens. One of them involves EMG monitoring of cases where there is neurosurgical intervention around spinal nerve roots. This is an important safety precaution. It is good for patients, it is well recognized. And HCFA compensated this technology up until 1999. Then, when for what I can determine no good reason, they stopped compensation. Other third-party payers continue to compensate physicians for this technology. There is some expense in performing the test. It is a useful test. In our practice we have elected to continue giving all our patients this modality.

Basically, sort of the message that HCFA is sending out is that the compensation for our senior citizens is not going to be as great, and one could make the case their access to health care is not as great as other citizens. And I think that is not a good situation.

The fourth issue I'd like to talk about involves organ donation. And this is an example of one of the numerous regulations that are being propagated that have tremendous impacts on many parts of many, many issues. Organ donation is a big issue and there are many who need—full transplant recipients out there. They need these organs. And so as a neurosurgeon, I thought it my responsibility to have conversations with patients' families after a loved one has expired, and initiate some kind of interchange and say what many people might: Your father or your child is dead, there is an issue here about maybe letting someone else make use of his organs. It may be a kind, nice thing that your child or parents would want to have happen. And then if the family has said OK, then it has been our custom to have an organ transplant professional discuss this with the family.

It has worked out very well. Our hospital has been number one in the State of Georgia in organ donation. And I feel that that is good.

In 1999 HCFA propagated a regulation which demanded that a treating physician could not initiate this kind of conversation unless he went—he or she went to a 2-day course to learn the right way to do it. And, in general, what HCFA has done is essentially stopped that kind of communication, and I think that is awful. I think that is reprehensible. It is a violation of patient rights, free

speech, and everything else I can think of. And it is just not the kind of thing that should be going on in this country.

My fifth comment involves patients that are in our tertiary care center that have brain damage and they need to go to some kind of extended care facility. That is the best place for them. It is going to be better on their families and it also is the most—it is the best use of health care resources. The expenses won't be as great. They just don't need a tertiary care center.

What has happened is the compensation package that these extended care facilities receive is not adequate to allow them to accept the patient. So what happens is these patients—or if I could use this phrase, “shipwreck”—are in a tertiary care center for months at a time, very inappropriately. And this is not a good—this is bad. This is wasteful display of regulations. Then when the transfer is finally arranged, it is often at a great distance from the patient's family, sometimes even another State, which causes significant emotional distress and expensive commuting back and forth. This is something that Congress should check on.

Those are my five comments.

I now have three sort of general remarks. And this, the basic point I would like to make is that there should be better outcome analysis of the thousands of decisions that HCFA is making. It is a question of outcome analysis. When HCFA makes a decision, it shouldn't be a blind shot in the dark but its implications should be known and monitored.

The first of those is the impact on the patient's health. When HCFA denies an elderly patient very advanced technology, they need to be able to tell Congress what happens. If a dialysis patient can't get a nephrologist consult because of HCFA compensation policies and that is affecting that patient population, HCFA needs to be able to say, this is what happened to patients because of that.

The second general issue is that the financial impact of these decisions needs to be more broadly stated. It shouldn't be that HCFA merely saves the government \$2, but it should be how much is this costing society? If \$2 are saved and it costs \$10 in compliance costs, patient inconveniences, how much is it costing for families to travel 250 miles, take time off from work to see their elderly relative in a distant nursing home? That is something that ought to be looked into, and HCFA needs to tell Congress what those numbers are.

The third thing that HCFA should tell Congress about or be able to answer to is the impact of their regulations on the health care professions, particularly among physicians. Physicians are growing increasingly timorous and intimidated by HCFA policies, and that is not in the best interest of the patients in this country. There needs to be a strong and independent medical profession that can stand up for their patient rights against any comer, including third-party payers of all types, the government, insurance companies. Whatever it takes to protect their patient's rights, physicians need to feel like they can do it independently and they should not be intimidated or terrorized by HCFA. Thank you.

Chairman CHAMBLISS. Thank you, Dr. Robinson.

[The prepared statement of Joe Sam Robinson follows:]

PREPARED STATEMENT OF JOE SAM ROBINSON, M.D., NEUROSURGEON FROM MACON,
GA

My name is Joe Sam Robinson, and I am a practicing neurosurgeon from Macon, GA. I am pleased to have this opportunity to appear before the committee today to speak to you about the regulatory burdens that the Health Care Financing Administration (HCFA) places on physicians. From the perspective of a practicing physician, the task of HCFA seems immense. Its broad, overarching power makes it the dominant influence upon the American healthcare system. Its routine decisions and judgments touch the lives, either directly or indirectly, of nearly all Americans. Its work will not grow any easier, as budgetary restraints collide with an aging population whose health and well-being can often be preserved only by the judicious application of expensive and evolving medical technologies.

This aside, I find considerable room for improvement in the administration of HCFA. I do not wish to offer my comments in a partisan spirit, nor do I claim any special expertise in the intricacies of such a vastly complicated structure. But in the busy clinical setting in which I labor (the metaphorical "ground zero" of healthcare delivery), the actions of HCFA, despite its generally good intentions, often seem quite wrong.

Regrettably, I lack the ability to say what fully should be said, but I can offer a few random observations.

1. The sense of intimidation and fear of HCFA among physicians is widespread and troubling. Physicians of my acquaintance, though upset and concerned, recoil from any outright public criticism of HCFA. They fear that such testimony will evoke an audit by HCFA, or even worse, by the Internal Revenue Service. "Who knows," they ask, "what demons will be directed against you and your family as revenge for testimony in Washington?" I regret such fears are present, but in my opinion the agency has engendered these fears among well meaning healthcare providers in many locations all across the country.

2. HCFA regulations are so excessively complicated, voluminous, and changeable that full compliance even among the most motivated is difficult. My office, for instance, receives about 35 pounds by weight of HCFA regulations every year. I personally wish to attend to the medical needs of my patients, which is why I went to medical school. I am not a professional coder and would rather spend my time discussing neurosurgical treatment options with patients, not in coding seminars. I am forced to depend on my office personnel to respond to the extraordinary amount of government regulations that HCFA has engendered so I can continue to tend to my patients' needs. If, however, my office makes some kind of error in following these regulations, I am the one who bears the responsibility for the error. As no one can be sure such errors do not exist, every physician fears himself vulnerable to reprimand, and thus quakes at any HCFA fiat.

For example, a number of years ago when HCFA first instituted new rules for coding medical office visits—the so-called "Evaluation and Management Documentation Guidelines"—I found the rules quite confusing. Wishing to be in compliance with these regulations, our office elected to charge every patient the lowest possible level visit, thus saving the Federal Government a good deal of money. We imagined we would avoid an audit by this tactic, since we were undercharging the Medicare program. However, both advisors and fellow physicians warned us that such conduct was still actionable and would provoke an audit. We were therefore forced to increase our office charges to attempt to comply with HCFA's very complicated coding regulations. As an aside, you may be interested to know that HCFA has yet to finalize these regulations. In fact, HCFA is currently using two different versions of these draft rules, making it even more difficult for physicians to figure out what is required of them, while we remain subject to audits and sever penalties if we fail to follow these draft regulations. This is simply unfair.

3. HCFA often restrains the growth of appropriate new medical technology by refusing to compensate such procedures or compensating the technology at such a low level that effective application of such technology is difficult. For instance, there is significant evidence in the medical literature that electromyographic monitoring of neurosurgical procedures in which spinal nerves are decompressed promotes a good clinical outcome. It has been our custom for a number of years to routinely employ such technology in many operative cases. Initially, we were reimbursed by HCFA. In 1999, however, for no apparent reason, the compensation abruptly ceased. Believing it is in our patients' interest to use this technology, we have elected to bear the expense of such monitoring rather than deny it to our patients. We have been told that we can appeal HCFA's decision, but informally have received information that such appeals are almost never accepted and we should not count on a reinstatement of the charge.

Another example of such a restriction in our practice is our effort to develop a functional neurosurgical program in our area of Georgia. Such a program has the potential to help a good number of patients who suffer from movement and other disorders, by using deep brain stimulation devices. While HCFA does pay for these procedures, the compensation is at such a low level that we simply are unable to make use of this exciting new technology. Since most third party payers follow the HCFA coding and reimbursement procedures, all citizens in our part of the state have basically been denied access to this technology.

4. Organ donation regulations do not promote discussions with patients about organ donation options. As a neurosurgeon, it is has often been my responsibility to inform family members when the earthly life of a loved one has ceased. In the past, in the course of such a discussion I have mentioned the usefulness of organ donation. This is a responsibility that I take quite seriously. Indeed, I have published an article in the Georgia State Medical Journal on this very subject. Following a general discussion about the good things that organ donation can accomplish, I used to refer the affected family to a representative of an organ retrieval service where detailed questions could be answered in a kind and gentle way. The families of many of my patients generally agreed to organ donation based on this local system, which I believe functioned in a kind, beneficial and humane fashion. In 1999, however, new HCFA regulations forbade any physician who had not been through a 2-day HCFA approved course on the subject of organ donation to broach this issue with the patient's family. Such a regulation effectively curtails useful involvement of the deceased patient's treating physician and severs the role of someone who is often a trusted friend, from this important decision. In my opinion, this new HCFA regulation represents a wrongful intrusion in the doctor/patient relationship, and displays a cavalier restriction upon the rights of free American citizens. With such a scarcity of organs and long organ transplant recipient waiting lists, HCFA should be doing everything in its power to encourage, not discourage such discussions.

5. HCFA's long-term care facility compensation policies have on occasion increased healthcare costs and have initiated significant family distress. A good example is the placement of brain injury patients in appropriate long-term care facilities. As compensation is quite inadequate, long-term care facilities are often reluctant to accept patients, forcing them to remain in far more expensive tertiary care facilities for often months at a time. When discharge occurs, it is often to a location at great distance from the patient's family. This happened to me recently, when one of my patients was discharged to a facility in another state, over 250 miles from his family.

In many ways, our vast half-public, half-private healthcare system is the best in the world. Unfortunately, however, over the years HCFA has come to dominate this healthcare system. While attempting to maximize efficiency, improve outcomes, equalize treatment costs, and diminish expenses, its actions have regrettably often had contrary, unintended effects. I would therefore suggest an increased oversight and analysis of HCFA policies, rules and regulations. Those policies, which adversely impact the physician/patient relationship and patient health, should, in particular, be rigorously assessed. Additionally, the total expense of such regulations, including total compliance expenses should be more closely monitored.

Finally, there is another more general issue on this topic that should be closely monitored by Congress: the effect HCFA policies have on diminishing the independence of the medical profession. Such independence is part of a broader system of checks and balances, which ensures the use of governmental power is judicious and restrained. Retention of this independence is in the high national interest.

Once again, Mr. Chambliss, and other members of the Committee, thank you for the chance to meet with you today on this important issue. My fellow physicians and I want only to do our very best to take care of our patients. The time is right for Congress to seriously reevaluate the HCFA rules, regulations and policies that interfere with this basic goal.

I would be pleased to answer any questions that you may have.

Chairman CHAMBLISS. Ms. Murray.

STATEMENT OF KATHLEEN G. MURRAY, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, NORTHWESTERN MEMORIAL HOSPITAL, CHICAGO, ILLINOIS; ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Ms. MURRAY. Mr. Chairman I am Kathleen Murray, the executive vice president and chief operating officer of Northwestern Memorial Hospital in Chicago. I am here today on behalf of the Amer-

ican Hospital Association's nearly 5,000 hospital, health system, and other health care provider members. We are pleased to have the opportunity to testify on the complexity and burden of Medicare's regulations on providers.

Because hospitals and health systems are entrusted with the lives and health of people, we are among the most regulated fields in America. For example, the Mayo Clinic in Rochester, Minnesota determined that hospitals are subject to 132,720 pages of Medicare rules. A breakdown of those rules, or the largest numbers of those rules, is on Chart A in front of us. This just represents some of the largest categories of the 132,000 pages.

Every day, hospitals and health systems submit about 200,000 Medicare claims. That is roughly 72 million per year. In 1997, close to 12 million Medicare beneficiaries received acute care services. For hospitals to be reimbursed for the care we provide to our Nation's seniors, we must follow the maze you see here in Chart B. I know you have a copy of this and can't see it there, but at the very top, on the right-hand side, it says that we must spend 20 minutes asking questions of patients about their secondary coverage. A new requirement is that we have to get this information every single time a patient presents.

So if you are a cancer patient and you are coming for radiation therapy three times a week, three times a week we have to ask you all of these questions and take 20 minutes of your time to refill out the Medicare secondary payer questionnaire. Complying with this Medicare billing maze is no small task. At Northwestern Memorial, the billing department alone spends more than 3,200 hours per month, or 38,400 hours per year, sorting through Medicare billing requirements.

In addition to Medicare, hospitals and health systems face laws, regulations, and instructions from Medicaid, the Occupational Safety and Health Administration, the Environmental Protection Agency, the Centers for Disease Control, the Internal Revenue Service, and numerous other regulatory agencies. Chart C demonstrates the massive web of regulators to whom hospitals must answer. As you can see, there are at least 29 other organizations issuing some type of rules, regulations, or instructions to hospitals. Hospitals' regulatory burdens are getting heavier and heavier.

Through the Balanced Budget Act of 1997, Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system. The new system, slated to take effect this July 1, is more complex than the inpatient PPS system implemented in the early eighties, yet it will be shoehorned into place over the next few months. For us it means reviewing over 10,000 new charge codes without any vendor available to provide billing software to assist us in the over 525,000 outpatient tests we bill for every month.

Recently the AHA sent a letter to HCFA expressing our concern over inaccurate and misleading HCFA training material and a lack of detailed information that hospitals need to properly comply with their directives. It seems that every regulation HCFA issued was followed by correction notice after correction notice. This complicates and hinders our ability to implement the changes in a timely fashion and is impeding the start-up of outpatient PPS. The

outpatient PPS introduced many new complicated coding requirements that add to those already in existence.

Worse still, hospitals must continue to operate and maintain two separate coding systems; this, despite the recommendation of the National Committee on Vital Health Statistics which recommended HCFA use only one coding system.

But in order to be reimbursed, hospitals are now required to collect the old inpatient ICD9 coded diagnoses for a growing portion of our outpatient services including lab tests. The vast majority of physicians do not provide ICD9 codes, the diagnosis information when ordering tests, for the simple reason that the test itself is needed to make the diagnosis. A classic Catch-22.

The effort and costs associated with outpatient PPS is extraordinary and wrong. Hospitals are forced to choose between providing the care for the patient or delaying the test until the proper code is received. Our choice has been to provide the test and risk no reimbursement. In fact we are currently holding \$3 million in Medicare laboratory billing for this reason, a sum that could destroy a smaller hospital.

On the heels of the new outpatient PPS implementation, hospitals face the overwhelming task of implementing the upcoming privacy security and administration simplification provisions of the Health Insurance Portability and Accountability Act of 1996, or HIPAA. Some experts estimate HIPAA implementation will cost \$43 billion over 5 years, much of which will be borne by providers.

Yet another Federal regulation in the pipeline is OSHA's proposed ergonomics rule. We believe that OSHA's estimate of the cost of this for hospitals is grossly underestimated. In addition, there are patient care implications. Complying with this growing mountain of rules and regulations comes at a high administrative price tag.

At Northwestern Memorial we have committed a great deal of time and resources to ensure that we follow State and Federal regulations. Our culture is to do the right thing. We have a corporate compliance officer who is also an experienced health care attorney. The hospital's corporate compliance committee, which I chair, includes nine other senior officers who meet monthly to discuss regulatory changes and compliance initiatives. We have an internal audit department with a staff of six and a number of outside resources who regularly and actively focus an increasing amount of time on Medicare-related compliance issues.

The rules are the same for smaller hospitals. How can they afford this? Besides the known expense of time and resources, burdensome regulations include hidden costs, a prime example being the toll they take on employee morale. Our employees came to Northwestern to take care of patients. The current regulatory environment buries good dedicated employees in bureaucratic paperwork. In today's tight job market, we face employee exodus to jobs that involve less red tape and hold the potential for greater job satisfaction. The necessity to constantly train and educate new staff in the intricacies of these burdensome regulations is another hidden cost that hospitals must bear.

In conclusion, hospitals' first priority is to provide high-quality care to our patients. Only a small percentage of these voluminous

regulations contribute to our efforts to provide quality patient care. The rest simply drain resources away from that goal. These burdensome regulatory rules also place a financial strain on providers who are already reeling from the drastic provider cuts in the 1997 Balanced Budget Act.

Mr. Chairman, we all agree the health care industry should be regulated. There is a valid reason why HCFA, the Joint Commission, IRS, and OSHA should monitor hospitals' activities. However, the strain of 29 or more organizations issuing rules, instructions, and laws is hurting the health of our Nation's hospitals. There is no coordination among agencies that regulate providers. Rules appear to be issued in a vacuum with no regard to the fiscal or practical consequences of compliance.

Most of the examples I have given today come from Northwestern Memorial's experience. I speak, though, for hospitals across the country, as these examples apply to all hospitals whether large or small.

The AHA is ready and willing to continue our work with HCFA and other agencies to improve the way rules and regulations are promulgated and implemented. We know that the size and complexity of the Medicare program is a challenge. We pledge to do all we can to help make the regulatory system work better, not just for hospitals and health systems but also for the patients and communities we serve.

Thank you very much for this opportunity.

Chairman CHAMBLISS. Thank you very much Ms. Murray.

[The prepared statement of Kathleen G. Murray follows:]

PREPARED STATEMENT OF KATHLEEN MURRAY, MEMBER, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Kathleen Murray, executive vice president and chief operating officer of Northwestern Memorial Hospital in Chicago. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network, and other health care provider members. We are pleased to have the opportunity to testify on the complexity and burden of Medicare's regulations on providers.

Though our history dates back to the days of the Civil War, the Northwestern Memorial of today was created in 1972 when two Chicago hospitals, Wesley Memorial and Passavant Hospital consolidated their services. It is the primary teaching hospital for the Northwestern University Medical School and enjoys a substantial national reputation. The hospital is staffed by more than 4,000 caregivers, including 1,000 physicians in 30 medical and surgical specialties, all dedicated to the organization's mission of putting "Patients First." Last year, Northwestern Memorial provided care for more than 260,000 outpatients and admitted close to 40,000 patients. The hospital has a diverse patient population in its urban locale, serving patients with many ethnic and socioeconomic backgrounds.

MAZE OF REGULATIONS

Because hospitals and health systems are entrusted with the lives and health of people, we are among the most regulated fields in America. For example, the Mayo Clinic in Rochester, Minnesota determined that hospitals are subject to 132,720 pages of Medicare rules. A break down of that overwhelming statistic is provided for you in Chart A.

CHART A.—REGULATION OVERLOAD

132,720 Pages of Medicare Rules

	No. of pages
Medicare Laws and Related Laws	706

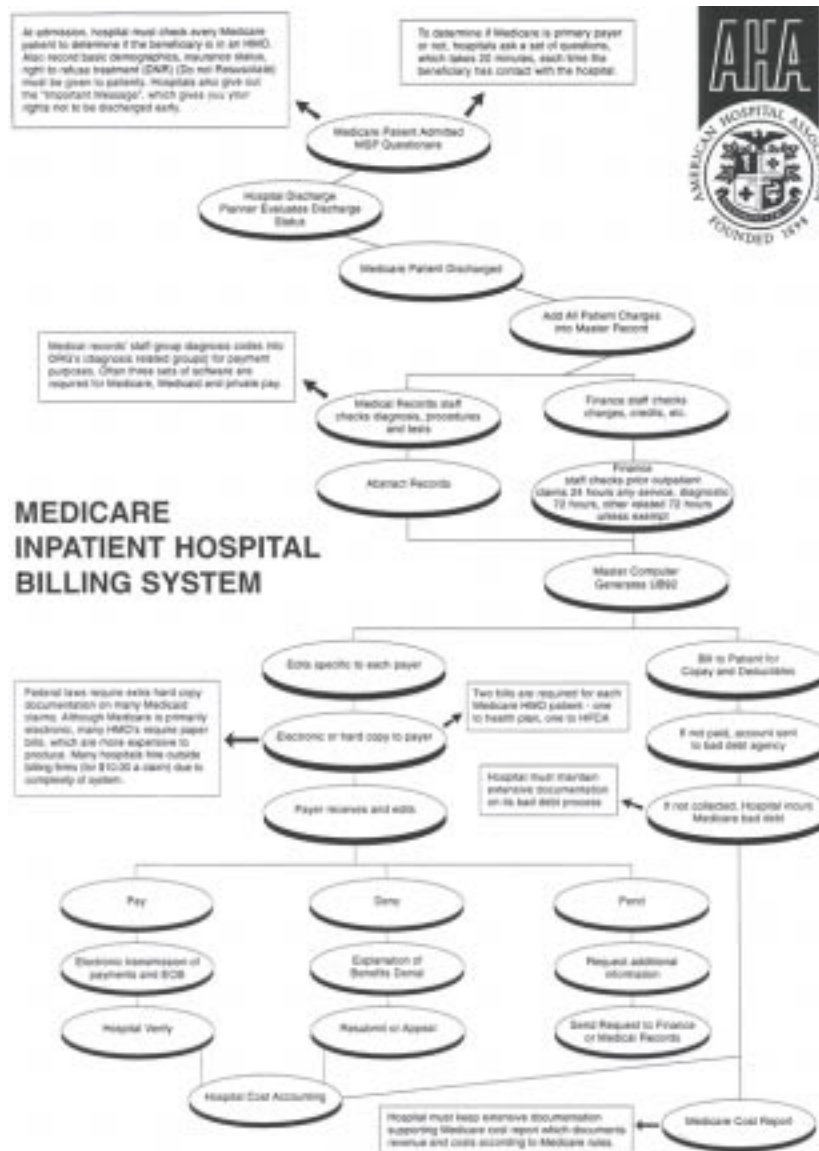
CHART A.—REGULATION OVERLOAD—Continued
132,720 Pages of Medicare Rules

	No. of pages
Medicare Regulations (42C.F.R.)	3,574
Fraud and Abuse Regulation	14,500
HCFA Registers ('94-'98)	30,000
Carrier Newsletters	4,320
Intermediary Communicators	2,880
HCFA Administrator Decisions	2,000

Source: Mayo Clinic.

Every day hospitals and health systems submit about 200,000 Medicare claims—that's roughly 72 million per year. In 1997, close to 12 million Medicare beneficiaries received acute care services. For hospitals to be reimbursed for the care we provide to our nation's seniors, we must follow the maze known as "Medicare Inpatient Hospital Billing System." If you look at Chart B, you will begin to understand the morass of regulations hospitals face.

CHART B



Complying with this Medicare billing maze is no small task. In fact, some rural hospitals have almost as many billing clerks as they do beds. In Gonzales, Texas, Memorial Hospital has 25 beds and a billing staff of 20 employees. At Northwestern Memorial, our patient financial services department alone spends more than 3,200 man hours per month, or 38,400 man hours per year sorting through Medicare billing requirements alone.

This volume of staff time is necessary because hospitals, health systems and other health care providers must comply with instructions from 43 different Medicare Part A fiscal intermediaries, and 28 Medicare Part B fiscal intermediaries. These

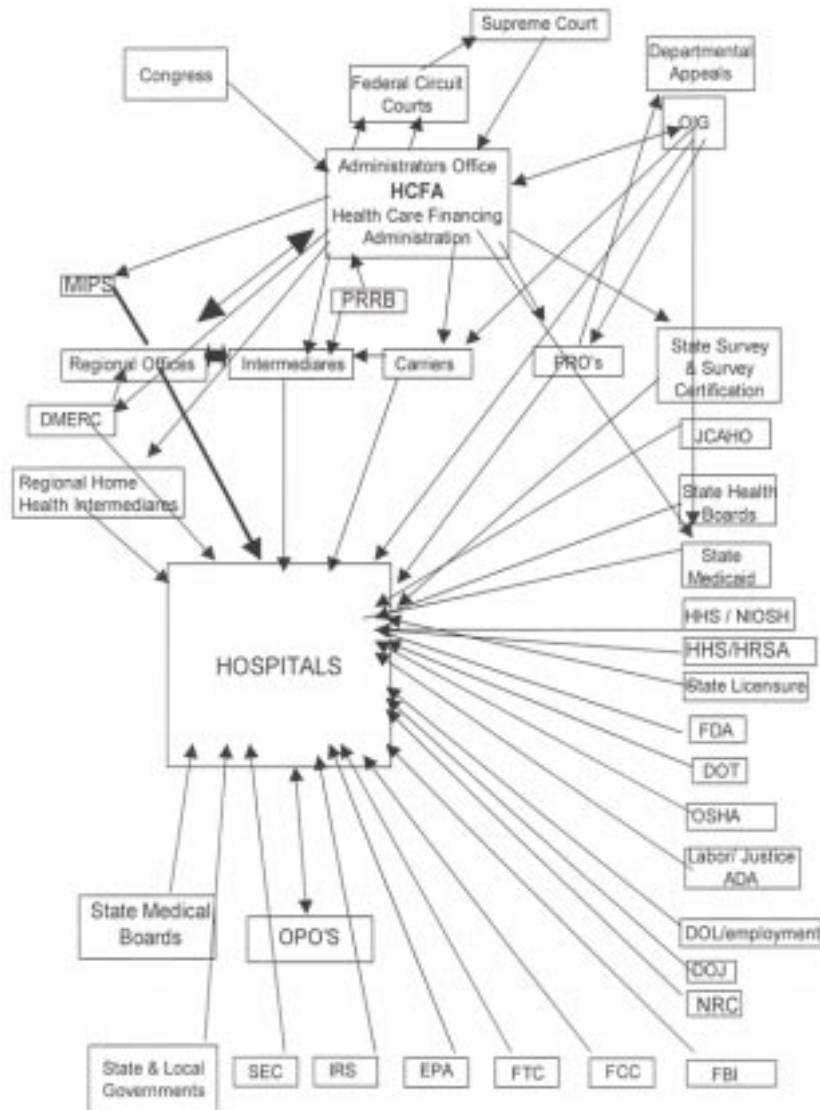
are private insurance companies that contract with the Health Care Financing Administration (HCFA) to process Medicare claims.

HCFA has delegated the responsibility of determining medical necessity to these local fiscal intermediaries. The vehicle for this determination is a publication called the local medical review policy (LMRP). An LMRP may be issued for diagnostic services, surgical procedures, lab tests, etc. Northwestern Memorial's fiscal intermediary, Administar, currently has 60 LMRPs, of which 35 are either new or significantly revised and reissued since January 1, 2000. Administar and Wisconsin Physician Service, the Part B fiscal intermediary, have only one LMRP in common. This indicates that physician practices, which have office-based diagnostic services, may not be subject to the same medical necessity standards as hospitals rendering the same service for the same reason. This has ramifications for patient care consistency and quality.

In addition to Medicare, hospitals and health systems face laws, regulations and instructions from Medicaid, the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency, the Centers for Disease Control, the Internal Revenue Service (IRS), and other regulatory agencies. Chart C clearly demonstrates the massive web of regulators to whom hospitals must answer. There are at least 29 organizations issuing some type of rules, regulations or instructions to hospitals. Depending on the type of facility and its location, there could be more than 29.

CHART C

Who Regulates Hospitals



To make matters more troublesome, many of our regulators issue conflicting and confusing rules. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently issued revised standards for the use of physical restraints and patient seclusion that differ from government requirements. JCAHO requires that an in-person evaluation by a health care provider be done within 4 hours of the beginning of restraint and seclusion. HCFA, on the other hand, requires that a face-to-face evaluation must occur within 1 hour.

REGULATORY BURDEN INCREASES

Hospitals' regulatory burdens are getting heavier and heavier. Using a patchwork of 13 different payment formulas, Medicare outpatient reimbursement is complicated and administratively costly for hospitals and the Medicare program. Through the Balanced Budget Act of 1997, Congress sought to simplify outpatient reimbursement by requiring HCFA to implement a prospective payment system (PPS).

The AHA supports an outpatient prospective payment system that is simple, predictable and fair. Unfortunately, between the enactment of the law and the drafting of the regulatory language, the new system is anything but. The new system, slated to take effect July 1, is more complex than the inpatient PPS implemented in the early 1980's, yet it will be shoehorned into place over the next few months. Ten thousand existing charge codes are being reviewed for appropriateness while upwards of 1,000 new codes may need to be opened. Additional documentation and coding will be required. Coinsurance and deductible determinations will be multi-variable calculations that will inevitably lead to errors for hospitals and confusion for patients. Detailed billing requirements and error reporting procedures that are not fully tested will be implemented simultaneously. Software support from vendors has not been finalized and the system will have little or no lead-time before going live.

Recently, the AHA sent a letter to HCFA expressing our concern over inaccurate and misleading HCFA training material, and a lack of detailed information that hospitals need to properly comply with their directives. It seems that every regulation HCFA issues is followed by correction notice after correction notice. This complicates and hinders our ability to implement changes in a timely fashion and is impeding the start up of the outpatient PPS.

The outpatient PPS introduced many new complicated coding requirements that augment those already in existence. Worse still, hospitals must operate and maintain two separate coding systems—this despite the recommendation of the National Committee on Vital Health Statistics, which recommended HCFA use only one coding system. In order to be reimbursed, hospitals are required to collect ICD9 coded diagnoses for a growing portion of our outpatient services, including tests. The vast majority of physicians do not provide ICD9 coded diagnosis information when ordering tests for the simple reason that the test itself is needed to make the diagnosis. Hospitals must spend inordinate amounts of time and money tracking down physicians for the appropriate ICD9 codes, or not be paid at all, as Medicare often rejects the general ICD9 code. Northwestern Memorial is holding \$3 million in Medicare laboratory billing for this reason, a sum that could destroy a smaller institution.

The effort and costs associated with outpatient PPS is extraordinary—and wrong. It forces hospitals to make decisions that could negatively impact patient care. Our only options are to absorb the costs of the tests without any possibility of reimbursement or to bear the costs of resubmitting the bills multiple times with no guarantee of payment.

The prospective payment system has implications for home health agencies, too, a branch of providers already at serious financial risk. The increase in required paperwork under PPS necessitated that Northwestern Memorial's home health agency hire an additional fulltime employee. These same reporting requirements reduce field nurse productivity and increase costs by \$3.03 per visit. HCFA responded by increasing reimbursement by a mere twelve cents per visit.

On the heels of the new outpatient PPS implementation, hospitals will face the monstrous task of implementing the upcoming privacy, security and administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Without significant alterations, implementation of this regulation could be extremely costly in terms of both dollars and increased liability. The Health and Human Services Secretary estimated that the regulation would cost \$3.8 billion over 5 years, with the bulk of the costs being borne by providers. However, that estimate includes the costs of only a few of the provisions. An earlier study based on similar policies estimated costs at \$43 billion over 5 years. The AHA has not done a formal cost estimate, but we believe the costs will be significant.

Yet another Federal regulation in the pipeline is OSHA's proposed ergonomics rule. Excluding the expense of retrofitting hospitals to eliminate and minimize patient lifting, OSHA's proposal is administratively pricey. Hospitals would need at least one new management position at each hospital. They would have to create a monitoring system and launch a massive employee education campaign. The AHA estimates that OSHA's ergonomics standard would cost hospitals and health system millions of dollars to implement—all with no sound scientific evidence that employee safety would increase or that injuries would drop.

COMPLIANCE COSTS ARE HIGH

Complying with this growing mountain of rules and regulations comes with a high administrative price tag. In HCFA's most recent comparison of wages, medical records and administrative cost centers showed the largest increases between 1996 and 1997, the period for which the most recent data is available.

At Northwestern Memorial, we take corporate compliance seriously. We have committed a great deal of time and resources to ensure that we follow state and Federal regulations. We have a corporate compliance department headed by a corporate compliance officer, who is also an experienced health care attorney. The hospital's corporate compliance committee, which I chair, includes nine other senior officers who meet monthly to discuss regulatory changes and compliance initiatives. We have an internal audit department with a staff of six, who regularly and actively focus an increasing amount of their time on Medicare-related compliance issues. Northwestern employs several outside consultants to help us prepare for review by HCFA and other agencies. In addition, we have numerous internal cross-functional task forces dedicated to ensuring compliance with regulations covering the Emergency Medical Treatment and Active Labor Act (EMTALA), coding, laboratory tests, patient observation and employee education, among others.

Besides the known expense of time and resources, burdensome regulations incur hidden costs—a prime example being the toll they take on employee morale. People choose to work at hospitals because they want to help others. The current regulatory environment buries good, dedicated employees in bureaucratic paperwork. In today's tight job market, we face employee exodus to jobs that involve less red tape and hold the potential for greater job satisfaction. The necessity to constantly train and educate new staff in the intricacies of these burdensome regulations is another hidden cost that hospitals must bear.

CONCLUSION

Hospitals' first priority is to provide high quality care to our patients. Only a small percentage of these voluminous regulations contribute to our efforts to provide quality patient care. The rest simply drain resources away from that goal. These burdensome regulatory rules place a financial strain on providers, who are already reeling from the drastic provider cuts included in the 1997 Balanced Budget Act. And as I said earlier, in addition to Medicare we face laws, regulations and instructions from some 29 other regulatory agencies.

Mr. Chairman, we all agree the health care industry should be regulated. There are valid reasons why HCFA, JCAHO, the IRS and OSHA should monitor hospitals' activities. However, the strain of 29 or more organizations issuing thousands and thousands of pages of rules, instructions and laws is hurting the health of our nation's hospitals. There is no coordination among agencies that regulate providers. Rules appear to be issued in a vacuum with no regard to the fiscal consequences of compliance.

Though most of the examples I have given today come from Northwestern Memorial's experience, I speak for hospitals across the country as these examples apply to hospitals whether large or small. The AHA is ready and willing to continue our work with HCFA and other agencies to improve the way rules and regulations are promulgated and implemented. We know that the size and complexity of the Medicare program is a challenge. We pledge to do all we can to help make the regulatory system work better not just for hospitals and health systems, but also for the patients and communities we serve.

I thank the Committee again for the opportunity to describe the difficulties hospitals are facing. I welcome any questions you may have.

Chairman CHAMBLISS. Before we go to Mr. Vaughan, just so we will know as a matter of comparison, Northwestern Hospital, what is the number of beds at that facility?

Ms. MURRAY. We have 700 beds.

Chairman CHAMBLISS. Mr. Vaughan, if you will tell us how many have you as you begin your statement and we will turn it over to you.

**STATEMENT OF PAGE VAUGHAN, EXECUTIVE DIRECTOR, EAST
GEORGIA REGIONAL MEDICAL CENTER**

Mr. VAUGHAN. Good morning Mr. Chairman and members of the House Budget Committee. I appreciate the opportunity to highlight the challenging regulatory environment hospitals are facing in these tough times. My name is Page Vaughan. For the last 5 years I have served as the executive director of Carolina Pines Regional Medical Center, a 116-bed facility. I have recently been appointed as the executive director of the East Georgia Regional Medical Center in Statesboro, GA, which is a 150-bed facility.

The negative budgetary consequences of the Balanced Budget Act, together with the industry's increased regulatory burden, have eroded the financial underpinnings of the Nation's Medicare program. Combined with the current enforcement environment, hospital CEO's fear that they are being treated as guilty until proven innocent. A specific recent regulatory change illustrates hospitals' frustration with the outpatient perspective payment system. HCFA has indicated for a year that these new changes would be effective in July 2000. The guidelines were only published several weeks ago. Clearly we understand HCFA's need to meet a deadline given. However, we are very concerned that hospitals and the Medicare contractors that actually make these payments to us will have insufficient time to implement this complex change.

The industry is working diligently with HCFA in an accelerated implementation time frame. We are very concerned that this effort will not be successful. While it is important that providers be held accountable, the constant reinterpretation of existing regulations that have been mirrored by my colleagues make it virtually impossible to always be accurate.

As a hospital CEO, I have significant staff hours, not only myself but many of my staff people, including clinical directors, invested in trying to keep up with the increasing and complex HCFA interpretations. Caregivers should focus on patients and not, again, on paperwork. And I think in a rural facility such as mine, we have less economy of scale of people and staffers to take care of these things. Quite often it does fall onto the shoulders of clinical people.

Despite the hard work of Congressman Spratt and others, the Balanced Budget Act of 1997 significantly reduced the amount of Medicaid patients' payments to disproportionate share of hospitals. For Carolina Pines, this reduction totaled approximately \$1.1 million last year. This cut plus the BBA-imposed reduction in our Medicare bad debt has severely hurt our efforts to reach out to the community to meet the very complex needs of the area's indigent.

The focus in Congress should be on how to reform the Medicare program and away from persistent cutting of provider reimbursements. Bottom line, we lose money on a lot of Medicare services to Medicare patients, and no other health care provider can be expected to continue to perform quality services, again with negative reimbursement.

This country is faced with an increasingly older population with more complex needs as the years go by. We are serving these individuals with a beleaguered delivery system. The regulatory and financial burden that I must operate under as a hospital administrator is driving too many of my resources away, again, from pa-

tient care and toward paperwork and, again, the other activities involved in regulation. This, again, is not good for my patients or these people who, again, are your constituents.

I appreciate the opportunity to testify and your interest in enhancing the quality, again, of our Nation's health care system, which personally I believe, as most people in this room, is the best in the world. I welcome any questions that you may have at the appropriate time.

Chairman CHAMBLISS. Thank you very much Mr. Vaughan.
[The prepared statement of Page H. Vaughan follows:]

PREPARED STATEMENT OF PAGE H. VAUGHAN, EXECUTIVE DIRECTOR, CAROLINA PINES REGIONAL MEDICAL CENTER

Good morning, Mr. Chairman and members of the House Budget Committee, I appreciate the opportunity to highlight the challenging regulatory environment hospitals are facing in these tough financial times.

My name is Page H. Vaughan, for the last several years, I have served as the Executive Director of Carolina Pines Regional Medical Center a 116 bed facility that provided more than 45,000 outpatient visits and had more than 6,000 inpatient admissions last year. Our patient mix at Carolina Pines is approximately 40 percent Medicare, 20 percent Medicaid, 30 percent private pay or "commercial;" the remaining 10 percent are indigent care patients for whom we receive no compensation (obviously a significant fiscal issue). I have just been appointed to be Executive Director of the East Georgia Regional Medical Center in Statesboro, GA.

The community we serve at Carolina Pines Hartsville—is largely rural with some manufacturing. We have industries as diverse as the world headquarters of Sunoco, to a "Sting Ray" sports boat manufacturing facility, to South Carolina's traditional textile industry, and the highly regarded Coker College. In short, we are "middle America."

From the pending implementation of the prospective payment system for outpatient services, to the ongoing and unintended negative impact of the Balanced Budget Act of 1997, one thing is very clear to those of us delivering health care on the front line: policies and regulations appear more often than not to be coming out of Washington, DC, without serious concern for hospitals' ability to implement these changes in the time frame necessary, and seemingly without regard to how the changes may affect the quality of patient care. Washington appears to be focused only on the budgetary bottomline. The current crop of policies and regulations has shown us this in spades!

This is not to suggest that some regulations haven't succeeded in clamping down on some "waste, fraud and abuse" in the Medicare program. No one, least of all providers and beneficiaries, want to see any fraud take place. However, the unfolding negative budgetary consequences of the Balanced Budget Act, together with the industry's increased regulatory burden, have eroded the financial underpinnings of the nation's Medicare program. Combined with the current enforcement environment, hospital CEO's fear that they are being treated as "guilty until proven innocent."

Let me highlight two specific recent regulatory changes that illustrate hospitals' frustration.

The first involves the Hospital Outpatient Prospective Payment System (HOPD PPS), and the encouraged use of Advanced Beneficiary Notification (ABN) by the intermediaries. The Ambulatory Patient Groupings (APC's) are a new and unique way to reimburse hospitals for outpatient services on a prospective basis replacing the old cost-based system (A \$17 billion per year system that accounts for 10-15 percent of an average hospitals' revenue). HCFA has indicated for a year that these new changes were coming and that they would be effective in July, 2000. Unfortunately, the guidelines were only published a couple of weeks ago. Clearly, we understand HCFA's need to meet a deadline. However, we are very concerned that hospitals and the Medicare contractors, that actually make payments, will not have sufficient time to implement this complex major change in the way we conduct business.

HCFA is going forward with critical implementing changes even when the Medicare fiscal intermediaries have raised concerns that they may not have their systems in place and tested given the extremely short implementation time frame. Hospitals run the risk of submitting incorrect bills due to lack of instructions and implementation time for training and systems changes. One of our concerns is that these bills, submitted in a good faith, but never the less possibly in error, could retro-

actively be classified as fraudulent by the enforcement community. The industry is working diligently with HCFA on an accelerated implementation time frame. And, HCFA to their credit are working very hard to try to make the best of a difficult situation. We are very concerned that this effort will not be successful. I would hope that Members of this Task Force will focus their attention on helping HCFA to ensure that an infrastructure is in place.

A second major change involves the encouraged use by the HCFA—through its fiscal intermediaries—of Advanced Beneficiary Notifications, as a process to inform the patient of those services provided to Medicare beneficiaries that HCFA has determined to be “Not Medically Necessary or Screening,” and as such not covered under Medicare.

First, HCFA and our local fiscal intermediary will argue that nothing has changed, and in fact, the regulations haven't even been rewritten. HCFA, however, through the fiscal intermediaries (in our case, Mutual of Omaha) continually issues interpretations, advisories, alerts and local medical review policies (LMRP) that guide hospitals. And even if the regulations do not change, it is this guidance that has completely confused us and has caused hospitals to focus on a more extensive use of the ABN. It would not be an overstatement to suggest that it would take a detective to find clearly written policy from HCFA concerning ABN's, their use and recent changes. The paragraph below comes directly from existing HCFA policies.

Providers are responsible for knowing the rules and regulations that apply to all services they are billing to the Medicare program. According to the Medicare Intermediary Manual, Section 3432.2, “Hold the provider liable for non-coverage of services if it is determined that the provider: (1) had actual knowledge of the non-coverage of services in a particular case, or (2) could reasonably have been expected to have such knowledge.” In general, provider should have known a policy or rule if the policy or rule is in the Federal Regulation, Medicare Manual governing the provider type, or is made through publication from the Intermediary which includes, but are not limited to, the Part A news and mailings sent periodically to all or individual providers * * *

This statement is being used to hold providers accountable for all regulations and the reasonable interpretation of regulations contained in these more informal advisories before a hospital ever submits a bill. While it is important that providers be held accountable, the constant reinterpretation of existing regulations makes it virtually impossible to always be accurate. As a hospital CEO, I have significant staff hours invested in trying to keep up with all these HCFA interpretations. In fact, hospital staff spends increasing amounts of time dealing with this growing paperwork burden, shifting resources away from the patient care that should be our focus. Caregivers should focus on patients not paper.

As the Executive Director of Carolina Pines, two other Federal issues have had a severe negative impact on the Hartsville community.

First, the Balanced Budget Act of 1997 significantly reduced the amount of Medicaid payments to disproportionate share hospitals (DSH), and for Carolina Pines, this reduction totaled more than \$1 million dollars last year—with a significant impact to our bottom line. This cut, plus the BBA imposed reduction in Medicare Bad Debt, has severely hurt our efforts to reach out into the community to meet the health care needs of the area's indigent population. And, I mentioned earlier about 10 percent of our care is indigent or unreimbursed.

Second, in the Medicare program, hospitals, nursing homes and home health agencies are all being paid on a per service basis and not a per cost of delivery. However our suppliers still require us to pay them on a cost basis, leaving us in a very precarious position.

To illustrate, Medicare pays Carolina Pines, like other hospitals, approximately \$7,000 for a hip replacement. However, the joint implant costs between \$3,000 and \$4,000. The average number of hospital days for a normal recovery for this procedure is 3 days. So, you can see how little of the total \$7,000 can be used to pay the 4-5 person surgical team that performs the procedure, to pay for the drugs and other materials used during the procedure, to pay for the associated rehabilitation of the patient, and to pay the nursing costs spent during the patient's recovery. Bottom line, we lose money on almost all Medicare patients, and no health care provider can be expected to continue to perform quality patient care with negative reimbursement.

There are several other areas where we have serious concerns about complicated regulatory requirements including: medical records privacy, filing of cost reports, provider enrollment and changes to the Medicare “Conditions of Participation.” The Federation of American Health Systems or I would be happy to follow-up with you

and your staffs on the regulatory issues associated with our compliance with these Federal standards.

Health care is changing dramatically and we are living under ever changing complex regulations. This environment makes it very difficult for hospitals to function. I know we provide the best health care in the world. But hospitals lack of appropriate reimbursement has made them short on capital to invest in technology, and on staff to meet the needs of both today and tomorrow's Medicare beneficiaries. The primary reasons for this are the 1997 BBA and the aggressive regulatory intervention of the Federal Government, both in reimbursement and compliance.

The focus in Congress should be on how to reform the overall Medicare Program to bring it into the 21st Century, and away from persistent cutting of provider reimbursement for budget reasons unrelated to health policy. This country is faced with an increasingly older population that is being served by an unstable health care delivery system. Believe me, as a hospital CEO, my first responsibility is to my patients, they depend on me. The regulatory and financial burden that I must operate under is driving too many of my resources away from patient care and toward paperwork. That is not good for my patients or your constituents.

I appreciate the opportunity to testify and your interest in enhancing the quality of our nation's health care system.

Chairman CHAMBLISS. Let me just say that in going over the schedule again with staff here, I didn't realize that somebody has this room at 12 o'clock. And we have got a series of one 15-minute vote and five 5-minute votes. So we are probably looking at almost an hour before we are going to be back. So I want to take a minute to get into a couple of questions, but then come back and give those that have questions an opportunity within the limited time to try to do so. But also, as I will remind you at the end, anybody who has written questions you would like to submit to any witness, I would hope our witnesses would be willing to respond to those in writing and they will obviously go into the record. I think there will be a lot of that.

Also we have got a number of both solicited and unsolicited written testimony coming in for today's hearing and I would like to ask unanimous consent to ensure that members have up to 7 additional days from the date of this hearing to put into the record any other testimony that you wish to put in. Is there any objection? If not, so agreed to.

[The information referred to follows:]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR HOMECARE

The American Association for Homecare (AAHomecare) appreciates the opportunity to submit this statement for the record of the Health Care Task Force of the Budget Committee. AAHomecare is a new national association resulting from the merger of the Home Care Section of the Health Industry Distributors Association, the Home Health Services and Staffing Association and the National Association for Medical Equipment Services. AAHomecare is the only association representing homecare providers of all types: home health agencies and home medical equipment providers, be they not-for-profit, proprietary, facility-based, freestanding or governmentally owned. As providers of all end-user home health care services, AAHomecare members are able to provide unique "ground level" insights into the impact of Medicare's regulatory burdens.

HOME HEALTH AGENCIES

Home health agencies (HHAs) provide skilled nursing care, therapy and home health aide services to individuals recovering from acute illnesses and living with chronic health care conditions. Health care services in the home setting provide a continuum of care for individuals who no longer require hospital or nursing home care, or seek to avoid hospital or nursing home admission. The range of homecare services includes skilled nursing; respiratory, occupational, speech, and physical therapy; intravenous drug therapy; enteral feedings; hospice care; assistance in the activities of daily living; skilled assessments; and educational services.

AAHomecare sincerely appreciates the efforts of this Committee and the Health Care Task Force in recognizing the importance of home health care. Your leadership in developing and supporting a recommendation to eliminate the additional 15 percent reduction in Medicare home health reimbursements was strategic and prudent. Home health reimbursements have already been reduced by much larger amounts than originally forecasted. As a result, the most frail elderly are experiencing problems with access to home health care. As you are aware, the additional 15 percent reduction will only exacerbate these problems.

The Health Care Financing Administration (HCFA) announced in January 2000 that home health services had a rate of growth of minus 4 percent, less than any other health care sector. Unfortunately, reductions this large have an inevitable impact on the availability of the homecare benefit. The George Washington University's Center for Health Services Research & Policy has released two studies reviewing the impact of the Balanced Budget Act of 1997 (BBA97) on home health patients and providers. The studies show that:

1. The number of Medicare home health patients has declined by 50 percent from 1994 levels and by 21 percent as a percentage of all patients in 1998 alone.

2. Patients who were most likely to lose access to covered services included those suffering from complex diabetes, congestive heart failure, chronic obstructive pulmonary disease, multiple sclerosis, skin ulcers, arthritis, and mental illness.

3. Physicians are increasingly hesitant to prescribe home health services even when they are medically necessary for fear of triggering a review or a penalty under the Medicare program.

Clearly, the current reimbursement environment is creating a hardship for home health agencies and threatening beneficiary access to medically necessary healthcare. This situation will only be exacerbated by a myriad of new Federal regulations imposed on homecare. These regulations represent real costs to home health providers and decreased dollars spent on patient care. The cumulative effect of these regulatory initiatives is to siphon crucial resources away from patient care.

EXPANSION OF OASIS TO NON-MEDICARE AND NON-MEDICAID PATIENTS

Medicare has required home health agencies to collect Outcome and Assessment Information Set (OASIS) survey data from Medicare beneficiaries for nearly a year. AAHomecare understands the need for a uniform data set for measuring patient outcomes in home care. We do not understand, however, why HCFA has recently determined that OASIS data must be collected from both Medicare and non-Medicare patients.

HCFA estimates that OASIS, as proposed, will impose an additional \$45 million in costs in the first year and \$110 million in costs over 5 years. They also concede that 70 percent of agencies will receive no Medicare reimbursement for these costs and that the new data reporting measures would require home health agencies to expend 967,600 hours of effort annually. Thus, already scarce financial and personnel resources will be further diverted from patient care.

HCFA maintains that OASIS data is needed to implement a prospective payment system (PPS) for home health agencies. However, HCFA has recently conceded that only 19 out of 79 OASIS questions are actually being used for the PPS system that will be implemented on October 1 of this year. AAHomecare believes that HCFA is already collecting information on Medicare and Medicaid patients that is more than adequate for the purposes of implementing the prospective payment system for Medicare covered services on October 1. In addition, the relevance of this information is highly questionable since the coverage and eligibility requirements for Medicare and Medicaid patients are different than those for non-Medicare and non-Medicaid patients. For example, patients must meet the complex criteria for being "homebound" as a condition of Medicare coverage, but there is no such requirement for most non-governmental insurance programs or for the many patients who pay for services privately. In fact, public harm will result if HCFA imposes an additional administrative burden on home health agencies to collect and report more information on more patients at the very time that the finances of home health agencies are being stretched to the breaking point by the startup costs of the new prospective payment system.

We also have serious questions about whether HCFA's use of the information is consistent with the notices sent to the patients. Patients who do not have Medicare and Medicaid coverage are to be given a notice which states that the OASIS questions are being asked "to make sure that you get quality health care services." (64 Fed. Reg. at 32991, June 18, 1999) The notice further states that the information will be made "anonymous" so that HCFA "cannot know that the information is about you." In reality, it would appear that HCFA as well as the state agency rou-

tinely surveying the home health agency would have access to unencoded OASIS data. Therefore, the information is not, in fact, "anonymous."

It also seems prudent to defer expanding the government's collection of OASIS data in view of recent actions by both the Administration and Congress. On November 3, 1999, the Department of Health and Human Services published proposed comprehensive medical information privacy regulations establishing new privacy standards for medical information that is transmitted electronically. (64 Fed. Reg. 59917) The collection, encoding and transmission of OASIS data would be encompassed within those standards. The Administration has indicated that it will publish the final regulations in the latter part of this year. If those standards impose new privacy protections (which is likely) home health agencies will have to incur the additional expense of changing the process for collecting and reporting the expanded OASIS data.

In the Balanced Budget Refinement Act of 1999, Congress directed the General Accounting Office (GAO) to study and report back to Congress (a) on the costs incurred by home health agencies in complying with OASIS and (b) "the effect of such data collection requirement on the privacy interests of patients." (See § 301(b)) GAO is just now in the process of assembling the research team for this project. It would seem prudent, particularly at a when the home health benefit has been so severely disrupted, to allow Congress and the Administration to consider the findings of the GAO report before expanding OASIS.

HOME HEALTH ADVANCE BENEFICIARY NOTICES

HCFA is also in the process of approving a revised Home Health Advance Beneficiary Notice (HHABN) to be given to Medicare patients where the home health agency believes that services prescribed by the patient's physician would not qualify for coverage under the Medicare home health benefit. (65 Fed. Reg. 24217) AAHomecare supports the use of standardized notices accurately informing patients of their Medicare rights. We have several concerns with the revised notice that HCFA seeks to have approved.

The notice estimates that complying with the HHABN requirement will consume 180,000 hours annually. (65 Fed. Reg. at 24217) These hours and associated costs result in another cut in funds that are already inadequate to provide the services that beneficiaries have a statutory right to receive. None of these costs appear to have been included in the calculation of the PPS base reimbursement rates. The new notice also appears to require agencies to incur unnecessary and duplicative costs. For example, a new page has been inserted into the notice that requires HHAs to inform beneficiaries of where they can obtain "free legal services." The "patient rights" provisions of the conditions of participation do not contain a requirement of any such notice. Home health agencies should not be expected to locate legal services for their patients.

In addition, the additional page requires the HHA to inform the patient of the number for the Area Agency on Aging and the state's toll-free home health hot line. The conditions of participation already require HHAs to notify patients in writing of the state's toll-free home health hotline number "when the agency accepts the patient for treatment or care * * *" (42 C.F.R. § 484.10(f)) Thus, this notice requirement is duplicative and should be stricken in accordance with 44 U.S.C. § 3506(c)(3)(B).

The notice states that the patient may submit any additional information, including additional information from the patient's physician, to the home health agency, which will then forward it to Medicare. We question whether the additional cost of collecting and forwarding this additional information was included in the estimate of 180,00 hours annually to implement this provision. Finally, the notices do not appear to provide for the situation where some, but not all, of the services ordered by the physician may not be covered by Medicare.

SURETY BONDS

AAHomecare's HHA members strongly supported the enactment of a home health surety bond at a maximum of \$50,000. We supported this provision in order to ensure that only high-quality home health providers are given the opportunity to serve Medicare beneficiaries. Congress enacted the new requirement as a part of the BBA97. When HCFA implemented the new regulations in early 1998, the requirement was expanded to the greater of \$50,000 or 15 percent of Medicare revenues. The HCFA requirement also permitted the use of the surety bond for Medicare recoupments. These requirements made it nearly impossible for a surety company to develop these bonds, and greatly increased the costs of the bonds that were available. The cost of securing a surety bond is not an allowable Medicare cost, which

made it very difficult for HHAs to obtain these bonds. For these reasons, we were not able to support the surety requirements enacted by HCFA.

ERGONOMICS

AAHomecare is also concerned about the proposed ergonomics program regulation recently promulgated by the Occupational Health and Safety Administration (OSHA). We believe that homecare should be exempted from the proposed ergonomics standard. OSHA's own cost estimates indicate that homecare providers would spend \$51.5 million in order to comply with the proposed rule. This places homecare in the fourth highest compliance cost category as a percent of total revenue out of the 42 affected industries. As stated above, the homecare industry is ill prepared to absorb these costs at this time.

In addition, homecare providers believe an exemption is necessary due to the lack of employer control of the work site. A 1993 Seventh Circuit Court decision in *HHSSA v. Martin*, 984 F. 2d 823, and the recent decision by the Secretary of Labor to withdraw the work at home OSHA policy only further supports the need for a homecare exemption. In *HHSSA v. Martin*, the Court found that the Occupational Safety and Health Act does not authorize OSHA to impose work site related standards on home work sites that are not under the employer's control. OSHA recognized the Court's findings in their November 1999 compliance directive on bloodborne pathogens, but failed to do so in the ergonomics proposed rule.

AAHomecare also believes that home health meets the standard qualifications for an exemption. While AAHomecare recognizes the importance of preventing work place injuries, it is difficult to understand how a regulation so broad in scope, covering manufacturing jobs, manual handling jobs, and jobs in which an employee experiences an OSHA-recordable musculoskeletal disorder (MSD), would be applied to the unique homecare environment. Homecare services are provided in a patient's home, which includes a broad range of conditions that homecare employers can not possibly control.

AAHomecare further believes that the recent withdrawal of the "work at home" advisory warrants an exemption for the homecare industry. The advisory indicates that OSHA will not attempt to impose OSHA standards on private homes, unless they are being used as a part of the manufacturing process. It is the Association's understanding that no further efforts will be made by OSHA to apply these standards to the home work environment until a national dialogue on the issue takes place.

Based on these findings, AAHomecare recommends including homecare on the list of industries exempted from the requirements due to the unfeasible costs and the lack of employer control in the home work environment.

HOME MEDICAL EQUIPMENT

Home medical equipment (HME) providers supply medically necessary equipment and allied services that help beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment and supplies to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other homecare providers (e.g., home health agencies and family caregivers) as an integral piece of the homecare delivery team. Specialized home infusion providers manage complex intravenous services in the home.

Medicare's durable medical equipment, prosthetic, orthotic and supply (DMEPOS) benefit is administered through four specialized regional carriers known as Durable Medical Equipment Regional Carriers (DMERCs). In addition, HCFA officials in Baltimore make national decisions regarding the administration of the DMEPOS benefit. AAHomecare's HME members consistently express their frustration with the inconsistency of the guidelines issued by the four DMERCs and unpredictable changes in national policies. All too often, these changes go into effect without any consideration of the operational impact on providers and with little or no notice. AAHomecare believes that these problems could largely be eliminated through better and more frequent communication between HCFA, the DMERCs and industry representatives.

POSSIBLE SOLUTIONS

AAHomecare believes that many of the regulatory problems associated with the Medicare DMEPOS benefit could easily be solved through increased and improved communication efforts. Specifically, we recommend that Medicare:

- Communicate with providers and provider groups prior to implementing changes in coverage policy or claims processing requirements.
- Seek comments from the industry with respect to the operational impact of proposed changes.
- Standardize policies and rules across the four DMERCs, including standardization of documentation requirements.
- Consider conducting “pilots” of certain operational changes prior to implementing them nationally.
- Improve the training of DMERC staff.
- Provide better education opportunities for the DMEPOS community.

A PARTICULAR CONCERN: CMNS

One particular regulatory burden has caused more consternation among HME providers than any other has; the certificate of medical necessity (CMN). The CMN is a form designed by Medicare to document the medical necessity of certain items of medical equipment. In addition, the CMN collects information necessary to determine whether the beneficiary meets Medicare coverage criteria for the DMEPOS item. In order to receive payment for a covered item of DMEPOS, a provider's claim (HCFA—Form 1500) must be accompanied by a CMN signed by a treating physician. The original CMN must be maintained by the supplier and must be produced upon the request of the DMERC, HCFA, or the Office of the Inspector General.

Providers often experience long delays in obtaining the completed CMNs because the provider cannot submit a claim for payment to the DMERC until the physician returns the completed and signed CMN. These delays lengthen the payment cycle for the supplier. At the same time, physicians are not penalized for failing to complete the CMN and often are unaware of the importance of this document. As a result, the DMEPOS supplier disproportionately bears the weight of physician non-compliance with CMN requirements.

The administrative burden that results from HCFA rules and DMERC policies pertaining to CMNs have been documented by industry and government studies. For example, the NAMES 1998 Industry Survey shows that the industry maintains higher than average outstanding accounts receivables because the medical necessity documentation in support of a claim often takes several weeks (and at times months) to obtain. The Industry Survey shows that median days sales outstanding for the industry ranges from a low of 81 days to a high of 108 days.¹ Likewise, the 1999 HIDA Home Care Financial Performance Survey reports that the median number of days outstanding for DMEPOS suppliers' accounts receivable has been rather steady at 84–87 days for the last 5 years.² In addition, the GAO included Medicare documentation requirements as one of the factors that account for a 30 percent difference in the administrative costs of serving Medicare beneficiaries when compared to individuals served by the Veterans' Administration (VA).³

POSSIBLE CMN REMEDIES

Physician Education: Physicians often fail to understand the legal ramifications of properly completing and signing a CMN. We continue to hear from our members that many physicians request compensation for completing the CMN. We also hear that physicians often tell our members that they will refer their business to suppliers who are willing to complete the forms. This is a continuing problem, although we acknowledge recent efforts to address this issue by the OIG. We urge HCFA to follow the lead of the OIG and develop an ongoing physician education program on medical necessity requirements. We believe that consistent and ongoing communication about the role of the physician in completing the CMN would promote compliance and improve the efficiency of the process.

Administrative Simplification: The DMEPOS supplier community has repeatedly requested permission to accept faxed CMNs from prescribing physicians to take the place of the original document. HCFA responded with a program memorandum stat-

¹ See NAMES Industry Survey, p. 11.

² See HIDA 1999 Home Care Financial Performance Survey, p.18.

³ See letter dated May 15, 1997, Re: Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen, from William J. Scanlon, Director, Health Financing and Systems Issues, GAO, to William V. Roth, Chairman, Committee on Finance, United States Senate.

ing that suppliers may submit a claim to the DMERC for DMEPOS services, if the supplier has received a completed CMN from the prescribing physician via facsimile. However, the supplier must be able to produce the original, hard copy CMN in the case of a post-payment review. The post payment review provision effectively negated the ability of the DMEPOS supplier to use the fax to transmit these documents, as very few suppliers will subject themselves to the possibility of recoupment. In practice, suppliers still must secure the original, hard copy CMN in order to avoid liabilities in an audit. AAHomecare welcomes the opportunity to work with HCFA to develop a secure and efficient means of transmitting CMNs electronically. Importantly, the Health Insurance Portability and Accountability Act requires HCFA to implement administrative simplification for claims processing and payment and we are prepared to assist HCFA in that process.

CONCLUSION

AAHomecare appreciates the interest of the Health Care Task Force in the considerable administrative burdens that the Medicare Program places on providers. We look forward to working with you and HCFA officials to support a strong homecare benefit that protects the interests of beneficiaries and preserves the integrity of the Medicare Program.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 115,000 physicians and medical students, appreciates the opportunity to submit a statement for the record to the Health Task Force of the Committee on the Budget on the regulatory burden the Medicare program imposes on physicians. ACP-ASIM commends the Task Force for its interest in this issue as it is imperative that the regulatory environment protect the integrity of the Medicare program without imposing an undue burden on physicians.

Medicare regulations are vast as physicians must navigate over 100,000 page of regulations pertaining to Medicare alone. A number of these regulations, such as those issued by Medicare carriers, are updated frequently. Physicians are concerned that the government's focus on fraud and abuse has increased at a time when Medicare regulations are becoming more and more complex. The government needs to ensure that billing errors are not treated as fraud and abuse. Internists frequently tell us that they will go to jail for the simplest of mistakes. Although we explain that the standard for demonstrating fraud and abuse is much higher, the government should be troubled that this perception is so widespread.

ACP-ASIM has worked with the Department of Health and Human Services Office of Inspector General (OIG) over the past year to ensure an appropriate anti fraud and abuse message. We have also attempt to allay internists' concerns about overzealous prosecution by presenting statistics showing that the government prosecutes very few physicians for fraud and abuse. We believe that we have made significant progress toward raising awareness among Medicare beneficiaries and the public regarding fraud and abuse while conveying that the vast majority of physicians are honest. We expect to continue our on-going dialogue with the OIG.

However, physicians will remain concerned that they are at risk to be investigated for fraud and abuse if the complex regulatory environment, which practically prohibits full compliance, remains unchanged. The OIG has an obligation to enforce the regulations that are in effect. We believe that the complexity of the regulatory environment is the root of the problem and that the government should commit to simplifying it.

The government can demonstrate its commitment to simplifying the current regulatory environment by:

1. Streamlining Medicare regulations;
2. Improving how regulations and regulatory updates are communicated to physicians; and
3. Improve physician education regarding Medicare regulations.

Further, we want to bring a several specific issues that are within the jurisdiction of the Health Care Financing Administration (HCFA) to the Health Task Force's attention. These issues are:

1. Documentation guidelines for evaluation and management (E/M) services;
2. Assessing Medicare carrier performance;
3. The Medicare medical review process; and
4. Proprietary, black box coding edits.

We believe these issues deserve Congressional attention as they are especially problematic for practicing physicians. We urge HCFA to adopt our recommendations and ask Congress to provide oversight.

NEED TO STREAMLINE REGULATIONS

The overall volume of Medicare regulations is tremendous. A document prepared by the majority staff of the House Committee on Budget puts the number of regulations at over 110,000 pages. This figure includes HCFA manuals, carrier Part B manuals and newsletters, fraud and abuse regulations, etc.

A significant portion of Medicare regulations are updated regularly. The experience of a physician who practices in Kansas illustrates the magnitude of the regulatory workload faced by physicians. The Kansas Medicare carrier regularly communicates policies to its physicians through: a Part B Physicians' Manual; Local Medical Review Policies (LMRPs); and Medicare communiques. These communications are not user friendly and that the sheer volume of regulatory instructions is overwhelming. The annual volume of regulations can most easily be measured by their height when stacked together. The Kansas carrier's Part B Physician's manual is approximately two and a half inches thick. The compilation of LMRPs totals about four inches. A binder containing the communiques, which are sent out once or twice a month, is about three-quarters of an inch thick.

Congress should establish a task force comprised of representatives from all agencies with Medicare jurisdiction as well as representatives from the physician community and charge it with compiling all Medicare directives into one accessible source. Overly burdensome regulations identified during this comprehensive review could be eliminated. All Medicare regulations should be contained in a single source (or as few sources as possible). A single entry could contain references to multiple laws as appropriate. However, a concentrated source of information is necessary to ensure consistency of information and to reduce the burden on physicians-reducing their costs and providing them more time to treat patients.

Streamlining regulations and compiling them into one accessible source will make it easier for physicians to adhere to Medicare directives. We believe that framework could be modeled after the HCFA Physician Regulatory Issues Team (PRIT). The PRIT is comprised of individuals from various departments within HCFA. It was formed to assess the totality of Medicare regulations and issue recommendations for improvement. However, it is our understanding that the PRIT has yet to make significant progress.

One of the few finding announced by the PRIT is that physicians view all Medicare regulations as "government" regulations; they do not associate specific regulations with the agency that promulgates them. This supports our contention that a review of Medicare regulations should be coordinated among all agencies with jurisdiction.

The congressionally established interagency task force we are proposing should be more open than the PRIT. It should seek broader physician input. We believe that the best way to assess the impact of regulations is to ask those who must adhere to those regulations. The inter-agency task force should provide frequent updates to Congress and the public regarding its progress.

NEED TO IMPROVE HOW INFORMATION IS DISSEMINATED TO PHYSICIANS

Requirements are communicated to physicians in a disjointed and ineffective way. Dissemination of LMRPs, which are policies that are specific to a particular Medicare carrier's area, are especially problematic. When LMRPs are updated, typically, only the changes are listed in the materials sent to physicians. The original policy is rarely updated and published in its entirety. The result is that individual practices have to update the original policies in their files to maintain accurate information, which makes it virtually impossible for physicians to learn LMRPs. Even the most well-informed physicians have difficulty keeping apprised of changing Medicare regulations.

Physicians find it extremely difficult to keep track of ever-changing Medicare regulations while treating patients. The problem is compounded for physicians in small group and solo practices, which make up the majority of rural practices. They do not have the staff to keep up with constantly changing rules. Although physician involvement in comprehending and applying regulations is likely to vary according to practice size, all physicians must be mindful of the universe of Medicare regulations. The magnitude and complexity of regulations is compounded for physicians that are covered by more than one carrier jurisdiction. Keeping track of the morass of Medicare regulations detracts from the time physicians have available to treat patients.

A single source for Medicare regulations that would result from an inter-agency effort will greatly enhance physicians' ability to adhere to regulations.

NEED TO IMPROVE PHYSICIAN EDUCATION

MEDICARE CARRIER PROVIDER EDUCATION AND TRAINING

Congress should allocate additional funding for Provider Education and Training to help physicians adhere to Medicare regulations. We are concerned that funding for carrier educational activities has failed to increase as regulations have become more voluminous and complex. The Administration's proposed fiscal year 2001 budget allocates \$15.8 million for Provider Education and Training. The proposed Provider Education and Training 2001 funding level equals the \$15.8 million that was allocated for fiscal year 2000 and represents approximately 1 percent of the 2001 \$1.3 billion contractor budget request.

MEDICARE INTEGRITY PROGRAM PHYSICIAN EDUCATION CONTACT

ACP-ASIM is pleased that HCFA is addressing physician education early in its implementation of the Medicare Integrity Program (MIP), recently selecting a contractor to implement the physician education task order.

HCFA must use the physician education task order to find mechanisms to get information to physicians and other providers in a useful and manageable way. Our understanding is that the contractor plans to assess current educational efforts and then develop and implement educational tools. HCFA must maintain its commitment to this process as it evolves. HCFA must also be committed to adequately funding the physician education initiative.

Further, it is essential that HCFA coordinate its education efforts agency-wide. It would be counterproductive for a segment of the agency's program integrity group to take actions that would undermine contractor physician education. For example, it would be inappropriate for the program integrity group to instruct carriers to issue overpayment requests based on extrapolating the results of a post-payment medical review if the contractor developed an educational approach to conducting review on those who have been audited for the first time. Similarly, other departments within HCFA must avoid contradicting physician education initiatives.

SPECIFIC REGULATORY ISSUES WORTHY OF CONGRESSIONAL OVERSIGHT

DOCUMENTATION REQUIREMENTS FOR EVALUATION AND MANAGEMENT SERVICES

Although ACP-ASIM is encouraged that HCFA is attempting to work with medical societies to improve the documentation guidelines for evaluation and management (E/M) services, the guidelines that were released in 1997 and currently in place dramatically increase the administrative burden.

The guidelines require physicians to spend a significant amount of time selecting which code to bill and documenting extensively to satisfy the comprehensive guidelines.

An internist who carefully reviewed the 1997 guidelines calculated the number of decisions that a physician must make before selecting a level of E/M service and billing Medicare. There are 11 decision points in categories to consider before selecting an E/M code. Each decision point requires several choices. There are 42 choices a physician must consider before selecting the proper level of E/M service. There are 6,144 possible combinations representing the number of ways an office visit for a new patient can evolve and be classified.

A physician must spend time documenting in the patient's record in addition to spending time deciding what is the appropriate level of service to bill. The guidelines put an undue excessive documentation burden on physicians for the sole purpose of billing, not for quality medical care. The guidelines force physicians to spend less time with their patients and more time with the patients' charts.

We expect that HCFA will soon announce at least its preliminary intent regarding the content of revised guidelines. Congress should ensure that the documentation standard selected by HCFA imposes a minimal regulatory burden. The Medicare Payment Advisory Commission's (MedPAC) agrees. MedPAC's 2000 report to Congress on Medicare Payment Policy MedPAC specifically states that "HCFA will need to consider avoiding overly complex and burdensome requirements for physicians, such as counting formulas that assign points for each element of a physician's service to determine the level at which services can be billed." It recommends that "HCFA should continue to work with the medical community in developing guidelines for evaluation and management services, minimizing their complexity, and exploring alternative approaches to promote accurate coding for these services."

HCFA has also committed to pilot testing the guidelines before they are fully implemented. The agency has yet to announce specific pilot testing approaches. ACP-ASIM recommends that any HCFA pilot test of the eventual guidelines should assess the amount of time physicians spend writing or dictating a patient's chart note to satisfy the guidelines. Guidelines that require physicians to spend too much time documenting information (beyond what is necessary for on-going care of the patient) unnecessarily interfere with patient care.

We also believe that HCFA should pilot test alternatives to the guidelines, such as allowing physicians to use time spent with the patient to determine what code to bill (while meeting a less onerous documentation standard). Academic research on this issue generally shows that time is a valid proxy for the amount of physician work involved in providing an E/M service.

In its 2000 report to Congress, MedPAC recommends that HCFA "should pilot-test documentation guidelines" and "continue to work with the medical community in developing the pilot tests, and should ensure adequate time for physician education."

Congress should also investigate as to whether more aggressive auditing of E/M services coupled with heightened fraud and abuse concerns have caused physicians to under bill for their E/M services. The MedPAC report demonstrates how past annual OIG financial audits of HCFA have led to intensified review requirements on physicians, possibly leading to undesirable changes in coding. MedPAC notes that beginning in 1998, "decreases began to occur for almost all types of E/M coding. This change occurred simultaneously with several factors, including heightened attention to the fraud and abuse issues in the Medicare program and random audits investigating documentation of E/M claims." The report notes that "results from the Chief Financial Officer's (CFO) audit of FY 1996 Medicare spending prompted HCFA to address concerns about the adequacy of documentation for services billed. Random audits grew from this impetus and the results of this and the subsequent two CFO audits further focused attention on fraud and abuse issues."

MedPAC observes that it is unclear why the change in 1998 occurred, saying that "it may reflect a return to a more appropriate level of coding" or "alternatively, the change may indicate the beginning of downcoding, that is physicians erring on the side of being overly cautious. This downcoding may be inappropriate, given that the beneficiary population is older and in poorer health and that Medicare+Choice programs generally draw low-risk individuals from the traditional program. These dynamics would predict a trend toward higher-level E/M codes."

PHYSICIAN INPUT INTO MEDICARE CARRIER PERFORMANCE

HCFA should establish a mechanism to assess valid regulatory hassles imposed by a specific policy or by carrier misinterpretation of HCFA policy identified by state and/or national medical societies. Carrier misinterpretation of national Medicare policy is problematic. Carriers are unlikely to recognize that their interpretation of a national policy is incorrect, leaving physicians no outlet to address their concerns. There are numerous instances in which a carrier(s) implemented a policy that inappropriately denied or reduced payment for services that were billed correctly.

We believe that HCFA can best identify hassles imposed by the current regulatory environment by listening to the concerns of individual physicians through their state and/or national medical society. Frustrated, rank-in-file physicians need a mechanism to address valid concerns. It is imperative that a process be established to listen and respond to these concerns so that physicians do not feel that the government is unresponsive to their legitimate concerns.

We envision that medical societies would only bring well-documented problems and/or carrier misinterpretations of national policy to the attention of the HCFA central office. We do not envision that frivolous or trivial policy matters would be brought to the attention of the HCFA central office. The HCFA central office would only become involved if a problem could not be resolved at the carrier or regional office level.

As noted above, it is our understanding that the HCFA regional offices are vital to addressing physician concerns regarding carrier policy. Individual physicians and their medical society representatives can have difficulty in locating appropriate regional office staff. The HCFA central office should designate a Medicare liaison in the each regional office to serve as a contact for medical societies and individuals. HCFA should make contact information available through its <http://www.hcfa.gov> Internet site. Providing medical societies access to central and regional office officials encourages dialogue and collaborative efforts to solve legitimate problems.

Maintaining a mechanism to collect and assess concerns about carrier actions will enable HCFA to be more informed regarding the performance of its carriers. The

General Accounting Office (GAO) recently issued reports detailing HCFA's general lack of oversight of its Medicare carriers and other contractors. HCFA cannot fully evaluate its carriers if it lacks a mechanism to collect documented inappropriate carrier actions. Also, the lack of such a mechanism unnecessarily antagonizes physicians by making it difficult for them to get relief for their valid concerns.

Further, HCFA communicates policy instructions to its Medicare carriers through Program Memoranda and other transmittals, which are then implemented by the carriers. HCFA should ensure that these instructions are clear to avoid misinterpretations. The instructions HCFA sends to its Medicare carriers should be reviewed by practicing physicians to promote clarity and to assure that the regulatory burden is minimized.

MEDICARE MEDICAL REVIEW PROCESS

The Medicare medical review process is a major concern of physicians. ACP-ASIM is encouraged that HCFA has contracted with the consulting firm of PricewaterhouseCoopers (PwC) to make recommendations to improve the effectiveness and the efficiency of medical review. We await the results of the contractor's report. However, the current medical review process denies physicians their due process. The design also coerces physicians into entering into a settlement with their carrier. Physicians often have a disincentive to prove their billing is appropriate as the legal costs involved in appealing an audit determination can rival the amount in question as the overpayment amount is often determined by extrapolating the results of a small sample.

Carriers should use detailed statistical analyses of severity-adjusted provider billing patterns to identify true outliers. Outliers who fail to exhibit egregious behavior should receive educational coding assistance before being subjected to comprehensive audits. While improved technology makes this possible, it is essential that carriers share the results of statistical analyses with providers and use them in a constructive manner.

HCFA should standardize the process for how carriers conduct medical review. The process then needs to be clearly communicated to physicians. Currently, carriers have wide latitude when conducting physician audits.

Program integrity entails paying claims appropriately in addition to detecting and preventing fraud and abuse. Carrier-initiated medical review should be furnished by a physician licensed in the same specialty as the physician whose claim(s) is under review. Also, appeal of overpayment requests over a certain monetary threshold should be conducted by an independent organization, such as the state Peer Review Organization. These steps would inject fairness and give physicians more confidence in the Medicare medical review process. HCFA should use the stable source of funding provided by Congress for the Medicare Integrity Program to assure fairness in medical review activities.

Physicians should be able to retain their appeal rights without opening themselves up to a more comprehensive audit. Currently, physicians must open themselves up to a review of the patient records pertaining to all claims for the identified service(s) over an open-ended period of time simply to maintain their appeal rights. In addition to opening oneself up to such a practice-disrupting audit, physician can accumulate substantial legal costs.

Physicians should not have to repay carrier-determined overpayment amounts until they exhaust all appeal rights and an accurate overpayment amount has been established. Currently, physicians must repay overpayments within 30 days even if the case is under appeal.

PROPRIETARY, "BLACK BOX" CODING EDITS

ACP-ASIM opposes the use of proprietary Commercial Off-the-Shelf Software (COTS), known as "black box" coding edit systems. Congress should instruct HCFA to refrain from entering into contracts with entities that maintain proprietary editing systems. Also, Congress should instruct HCFA to disclose all existing proprietary coding edits. We believe that such a closed edit system is inappropriate. The Medicare Correct Coding Initiative (CCI) demonstrates the need for a coding edit system that is open to peer review. ACP-ASIM and other medical organizations often identify numerous inappropriate coding edits in each proposed version of the CCI when HCFA distributes it for public review. Ideally, inappropriate edits are deleted or altered before they are implemented. The end result is that the claims payment system is more accurate because it had been appropriately peer reviewed. Many inappropriate edits would remain if the CCI was a closed system, which would deny payment for appropriately provided services.

While we understand that proprietary, black box coding edit systems are used to save money, we point out that the appropriateness of these edits cannot be judged solely on their ability to generate savings by denying payments to providers. The OIG report, "Using Software to Detect Upcoding of Hospital Bills," released August 12, 1998, questions the ability of commercial software to accurately detect inappropriate over-billing. The report, which analyzed two off the shelf software products currently on the market to identify hospital upcoding, found that only about 20 percent of the Medicare billing cases that commercially available software identified as being upcoded were in fact upcoded.

MedPAC takes a similar position. In its 2000 report, MedPAC recommends that "HCFA should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community."

There are numerous other issues that impose a regulatory burden on physicians. Examples include: random prepayment review of E/M claims; prescribing durable medical equipment and supplies, including completing certificates of medical necessity forms; and the Medicare provider enrollment process. The Task Force can contact our Washington, DC office for specifics.

Thank you for holding this hearing and for the opportunity to submit a statement for the record. We look forward to working with the Health Task Force and the entire Committee on Budget to reduce the Medicare regulatory burden imposed upon physicians.

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

On behalf of our 300,000 physician and medical student members, the American Medical Association (AMA) would like to thank the Budget Committee for holding this hearing to discuss the proliferation of Medicare regulations and their impact on health care providers. The government cannot continue to subject physicians to new Medicare regulatory requirements and burdens without commensurate reductions in existing Medicare rules and regulations.

BACKGROUND

Physicians today are spending far too much time trying to comprehend and comply with the Health Care Financing Administration (HCFA) policies and paperwork requirements rather than focusing on patient care. For the sake of patients, physicians, and the Medicare program, Congress and the Administration must take immediate action to simplify Medicare and reduce the excessive regulatory burdens that currently exist for physicians providing care to seniors.

Numerous examples of these unnecessary regulatory requirements exist. The following instances are illustrative of existing regulatory roadblocks for physicians:

- A physician was trying to secure a wheelchair for a quadriplegic patient. The carrier required the physician to supply a great deal of additional information, beyond the certificate of medical necessity and the appropriate diagnosis code, to verify that the chair was medically necessary. The fact that the diagnosis was for a quadriplegic patient should have sufficed.
- Under the Emergency Medical Treatment and Labor Act (EMTALA), when a patient presents at the emergency room, the physician must treat the patient without asking about his or her ability to pay. However, under Medicare if a physician ends up providing services that are not covered by Medicare, Medicare requires that prior to providing the service the physician must inform the patient that the service may not be covered. The physician must ask the patient to sign the Advance Beneficiary Notice, which says that the patient understands that he or she may be liable for the cost of the service. Under EMTALA, however, a physician cannot discuss payment with a patient.
- Physicians report that Medicare documentation requirements impose the greatest burden on their practices and do little to improve the quality of care. Physicians are forced to spend more time documenting their medical records and less time on patient care.

REGULATORY OVERLOAD

In recent years, HCFA has imposed requirement after requirement on physicians. This is due in large part to the extensive focus that Congress and the Administration have placed on addressing alleged "waste, fraud and abuse" in the Medicare program. Since the early 1980's, Congress has enacted the following fraud and abuse statutes:

- "Ticket to Work and Work Incentives Improvement Act of 1999;"
- "Balanced Budget Act of 1997;"

- "Omnibus Consolidated Appropriation Act of 1997;"
- "Health Insurance Portability and Accountability Act of 1996;"
- "Medicare and Medicaid Patient and Program Protection Act of 1987;"
- "Health Care Quality Improvement Act of 1986;"
- "False Claims Amendments Act of 1986;"
- "Medicare and Medicaid Budget Reconciliation Amendments of 1985;"
- "Medicare and Medicaid Budget Reconciliation Amendments of 1984;"
- "Medicare and Medicaid Amendments of 1981;" and
- "Medicare and Medicaid Amendments of 1980."

Legislation enacted over the last several years has dramatically escalated the billing and documentation requirements and their attendant penalties. Consequently, HCFA has been under intense pressure from Congress, the White House, the Department of Justice (DOJ) and the Office of the Inspector General (OIG) to promulgate regulations and policies to address perceived waste, fraud, and abuse problems.

The aforementioned legislation and regulations have had substantial negative effects on physicians, providers, and patients in the Medicare program. The cumulative impact of these laws and ensuing regulations has amounted to an insurmountable morass of bureaucracy, burden, and hassle for physicians. Physicians are confronted by an extremely complicated system of regulations with which it is virtually impossible to comply. In the current environment, it is difficult to know where billing errors end and fraud begins. Much of what carriers are pursuing is inadvertent billings errors. Frequently, these involve situations about which honest people can disagree.

There are more than 100,000 pages of Medicare rules and guidances with which a physician must comply. Physicians and their office staffs are absolutely overwhelmed by the current paperwork requirements generated by often poorly thought out regulations. In fact, physicians and their staffs have no single guidebook which they can consult for billing and coding questions. Rather, physicians' offices regularly receive reams of notices, guidances, and issuances from their carriers describing ever-changing policies and regulations. Vital information for the physician is often buried in these carrier communications, which can contain dozens of pages of new information each month. Not knowing of the information's existence could result in violations of new carrier or HCFA regulations or issuances.

In addition to being extremely voluminous, many Medicare policies frequently are unclear. Medicare billing is subjective in nature and involves understandable differences in opinion over clinical judgments or the level of service provided. Physicians have been forced to hire attorneys, consultants, and compliance experts to attempt to comply with these complex and continuously-changing regulations. A 1995 OIG report demonstrated the difficulty of complying with coding requirements. The report found that carrier personnel even had difficulty in selecting correct billing codes. Due to the confusion, physicians and their office staffs spend countless hours attempting to deal with the denial and resubmission of claims.

To further complicate matters, there is great variation nationwide in how carriers implement policies and procedures. Medicare coverage policies are also frequently inconsistent in different regions. Furthermore, physicians frequently have difficulty securing direct and consistent answers from carriers. Several years ago, just as the requirements on physicians dramatically increased, HCFA eliminated its carrier toll-free line service which had answered physicians' billing and coding questions. Ever since, the AMA has been urging HCFA to restore the lines. Although HCFA recently committed to reopening the toll-free lines, these lines have yet to be restored. Congress should require HCFA to reestablish these toll-free lines.

Even Federal legislation impacting physicians can be contradictory and confusing. For instance, the Medicare anti-kickback statute, the self-referral laws, and the False Claims Act cover the same types of behavior with different intent standards and different penalty structures. In addition, the Federal self-referral laws actually conflict with many state self-referral statutes, making physicians uncertain as to which standards they should follow.

In response to physician concerns with over-regulation, HCFA assigned a part-time physician employee to head an internal working group 2 years ago, known as the Physician Regulatory Initiative Team (PRIT). PRIT has had one public meeting seeking input but has failed to reduce the number of rules and regulations that physicians must comply with when treating Medicare patients or to produce a report that suggests a meaningful reduction in paperwork will be forthcoming. Instead, local carriers and HCFA's Central Office continue to promulgate new initiatives, place new administrative burdens on physicians, propose new forms for physicians to complete, and increasingly threaten physicians with audits of their medical practice if information is not submitted in a satisfactory manner to the Medicare program.

The AMA has several recommendations that would begin to ameliorate the regulatory overload most physicians are experiencing:

- Congress should take immediate steps to instruct HCFA to work with physician organizations to streamline and clarify existing regulations and policies.
- The AMA has endorsed H.R. 2651, the "Physician Self-Referral Amendments of 1999," introduced by Chairman William Thomas (R-CA), which would reform existing self-referral laws to ensure that commonplace business practices and group practice arrangements do not run afoul of the ban on self-referrals.
- The AMA has endorsed H.R. 3300, introduced by Representative Shelley Berkeley (D-NV), which would require HCFA and the Medicare carriers to educate physicians as to billing and coding changes. It would also prevent carriers from violating physicians' due process rights during audits by forcing physicians to settle in order to avoid expensive and time-consuming audits.
- The AMA requests that Congress call on the HCFA Administrator to report each year first, which regulations that have been eliminated or reduced, and second, which initiatives will relieve the administrative burden on the physician community.

INADEQUATE PHYSICIAN EDUCATION EFFORTS

With respect to waste, fraud, and abuse, Washington policymakers continue to focus on enforcement initiatives rather than education. HCFA's current education efforts are woefully inadequate. The agency's education initiatives present overly general directions that fail to aid individual physicians with specific Medicare coding and billing issues. There is virtually no individual outreach to a physician when he or she is identified by the carrier as making billing mistakes. In addition, physicians frequently cannot obtain written opinions from their carriers regarding their billing and coding questions. They are forced to rely on carrier personnel's oral advice which will not suffice if a problem later arises.

Surprisingly, HCFA does not have a program in place to address systematic billing errors in a region or within a medical specialty. Rather than education, HCFA's response is to conduct prepayment audits when an entire group of physicians does not understand the Medicare billing procedures and are billing incorrectly. In essence, HCFA has failed to create navigable pathways for physicians who attempt to understand the most current and appropriate way to bill and document their Medicare claims. The AMA strongly believes that in this "zero tolerance for errors" environment, the Federal Government has an obligation to emphasize prevention and education for physicians. The AMA strongly urges Congress to require HCFA and its carriers to conduct innovative and extensive education initiatives for individual physicians and to work with specialty and local medical societies in education efforts that would address the most widespread billing errors..

We would also like to note that the Administration has proposed in its Fiscal Year 2001 budget to allocate \$15.8 million in funding for Provider Education and Training out of a total Medicare contractor budget of \$1.3 billion. The funding level for provider education and training in Fiscal Year 2000 was also \$15.8 million. This funding level, which represents approximately 1 percent of the carriers' budget would not ensure that physicians and health care providers learn about new changes to Medicare laws and billing and coding requirements. It is particularly striking that HCFA has proposed such a miniscule level of funding for this activity at the same time that it has implemented new payment systems for hospitals, nursing homes and home health agencies. The AMA urges Congress to significantly increase funding for physician/provider education so that fewer billing errors occur and that the relationship between HCFA and physicians becomes less adversarial.

ENFORCEMENT ACTIVITY

The AMA believes that HCFA's actions and those of its contractors have created a strong fear among honest physicians that they will be targeted by their carriers with overly aggressive audits. The agency has transformed itself into the Internal Revenue Service (IRS) that existed before Congress heeded the demands of taxpayers and forced the IRS to restructure its policies. Just as the IRS is struggling to reinvent itself as a "taxpayer friendly" agency, HCFA must reassess its role and relationships with medical professionals who care for Medicare patients.

As a result of pressure from HCFA, the carriers are now carrying out a multitude of audits of physicians for alleged billing errors, with the result being that the Medicare claims submission process has become legally treacherous for physicians. The carriers and HCFA have readily acknowledged that these audits almost always involve billing errors due to the physicians' confusion regarding Medicare regulations. They do not constitute fraudulent billing. In fact, insurance policies are now being offered to cover physicians against future government audits where "Medicare can

conduct an audit and make an affirmative statement that the physician owes an extreme amount of money for very little justification at all." (Miami Herald, 2/7/00)

The AMA cannot underscore enough the devastating impact these overzealous actions are having on physicians, patients and the Medicare program. For example, in Denver, Colorado, many physicians have left the Medicare program. According to Jack Berry, MD, President of the Colorado Medical Society, they have done so because of "the fear of being targeted by the government's increasingly aggressive anti-fraud and abuse program." Dr. Berry stated further, "To some doctors, the final straw came last year when the government and the American Association of Retired Persons started recruiting seniors to inform on medical providers they suspected of fraud." (Denver Post, 2/13/00) Physicians across the country routinely have expressed these sentiments.

The Carriers Manual provisions relating to post-payment audits serve as an excellent example of rules that have gone awry and have resulted in the government's heavy-handedness and the deprivation of physicians' due process rights.¹ Once a carrier conducts a post-payment audit on a small number of a physician's claims, the carrier determines the amount owed to HCFA through extrapolation. As such, the overpayment calculation can rapidly rise to hundreds of thousands of dollars. Once the carrier arrives at this overpayment amount, the carrier gives physicians three options:

1. Repay the extrapolated amount and waive their appeal rights;
2. Repay the extrapolated amount and submit additional information while waiving their appeal rights; or
3. Open up their practice to a statistically valid random sampling (SVRS) of claims during the same time period. Thus, to preserve their appeal rights, physicians would have to agree to shut down their offices to allow the carrier to conduct the SVRS by auditing hundreds of charts. It is important to note that most physicians undergo these pre and post payment audits without the benefit of serious education efforts.

The AMA believes that HCFA must create an option that first, allows a physician to submit additional documentation on the cases previously audited while retaining his or her right to appeal without admitting liability, and second, does not require that the physician agree to a SVRS in order to appeal a finding and not admit liability. The AMA has been working for nearly 2 years to advance this change through discussions with HCFA. At this date, HCFA has still not agreed to change the post-payment audit options.

CONCLUSION

In closing, the AMA implores Congress to carefully scrutinize both the abundance of regulations impacting physicians and HCFA's and the carriers' inappropriate targeting of honest physicians. The AMA strongly believes that HCFA's paradigm for addressing physician billing errors should shift from its current punitive approach to one that stresses education. Complex Medicare rules should be simplified, physician education should be strengthened, and HCFA's oversight of carriers should substantially improve. The AMA urges Congress to take prompt action.

Thank you once again for holding this hearing and for the opportunity to submit testimony for the record. Please feel free to contact the AMA's Washington DC office with any questions you may have related to government activity in this area, and we look forward to working with you and your staff.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR HOME CARE

Thank you for the opportunity to submit written testimony for the record on the Medicare program's regulatory burden on home health care providers. The National Association for Home Care (NAHC) is the largest national home health trade association representing nearly 6000 organizations. Among our members are Medicare-participating home health providers, including non-profit providers like the visiting nursing associations, for-profit home health chains, hospital-based providers and freestanding providers. We also represent home care aide and hospice organizations.

NAHC is deeply appreciative of the interest the Chairman and Members of the Committee and its Health Care Task Force have shown in recognizing the importance of preserving home health services for seniors and disabled citizens. Your leadership in establishing and voting out of Committee, during budget deliberations, a Sense of the Congress on Access to Home Health Care, specifying the need to

¹ The Carriers Manual is a multi-volume, extraordinarily voluminous text that generally is not subject to the notice and comment process set forth in the Administrative Procedures Act.

avoid the implementation of the 15 percent reduction scheduled to take effect October 1, 2001, was strategic and prudent.

Since the enactment of the Balanced Budget Act of 1997 (BBA97) and imposition of the interim payment system (IPS), the Medicare home health benefit has been seriously eroded. As documented by several studies, access to care has become a major problem, particularly for patients with care-intensive needs. A prospective payment system (PPS) for home care is scheduled for implementation on October 1, 2000. The new system has the potential to better provide needed services to Medicare beneficiaries. However, the PPS will fall short of this goal if not properly developed and implemented, and adequately funded.

The Congressional Budget Office currently projects that home health outlays for fiscal years 1998–2002 will be reduced by \$69 billion, more than four times the amount anticipated in 1997 (\$16.1 billion). Home health spending was cut by 45 percent in the last 2 years. As a result, over 500,000 fewer beneficiaries received home care in 1998 than were served in calendar year 1997. Estimates for 1999 indicate a continuation of that downward trend.

Home health agencies, already under severe financial strain due to the IPS reductions, must also conform to a myriad of burdensome and costly regulations. Virtually all agencies are being reimbursed less than the actual costs they incur in providing care to Medicare beneficiaries. More and more new and costly demands associated with Medicare regulations are increasing agencies' financial and operational burdens and are straining agencies' ability to deliver quality care to their patients. While our testimony and the primary focus of this hearing is on Medicare regulations that affect and burden health care providers, it is important to note that the Medicare Conditions of Participation for home health require agencies to comply with all applicable federal, state and local laws and regulations. These other laws and regulations include Federal and state Occupational Safety and Health Administration requirements, such as standards for prevention of bloodborne pathogens or preventing transmission of tuberculosis, as well as reporting and recording work-related injuries and illnesses; medical device reporting under the Food and Drug Administration requirements, and state Medicaid statutes, among others. The cumulative effect of these regulatory initiatives has been devastating to providers and has siphoned scarce resources away from patient care.

Each year, NAHC identifies important regulatory issues for home care, hospice and medical equipment providers. NAHC's 2000 Regulatory Blueprint for Action provides a summary of each issue, recommendations, and a rationale for the recommendations. Our blueprint may be accessed at <http://www.nahc.org/NAHC/LegReg/blueprints.html>. The Committee and Task Force Members of the Committee are encouraged to view this Web site for a full and complete analysis of regulatory issues confronting the home health provider. For the purposes of this written testimony, NAHC will highlight several of the Medicare regulations that adversely impact the home health provider. These include requirements associated with implementation of OASIS, 15-minute visit increment reporting, increased claims reviews, expanded compliance surveys, surety bonds, sampling procedures for post-payment and audit reviews, sequential billing, and branch office restrictions. Many of these changes have been developed without adherence to regulatory procedural requirements.

REGULATORY BURDENS

In addition to the administrative and regulatory burdens listed below, home health agencies currently are undergoing significant changes, at great cost, to transition to a prospective payment system (PPS) and revised Medicare conditions of participation (CoPs) by October 1, 2000. The PPS requires providers to expand, modify and replace computer hardware, software and other technology to achieve compliance and retool operations to address new billing, accounting, claims management, and financial oversight needs. The CoPs are expected to significantly modify operations by requiring new quality assurance systems for home health agencies. The cost of transitioning to PPS and the new CoPs are not reflected in current payment limits or within the proposed payment rates under PPS. The changes required by PPS and the CoPs are unprecedented for home health agencies.

1. 15-MINUTE VISIT INCREMENT REPORTING

BBA97 required that claims for home health services contain a code that identifies the length of time for each service visit, measured in 15-minute increments. The Health Care Financing Administration (HCFA) issued instructions to the home health fiscal intermediaries (FI) on February 18, 1999, directing them to initiate necessary steps to implement this new billing requirement for all home health agen-

cies (HHA) participating in the Medicare program by July 1 of last year (Transmittal No. A-99).

This new administrative burden imposes a complex time-keeping requirement for agencies to stop the in-home clock when an interruption in active treatment occurs. The HCFA transmittal defines the "time of service visit" to begin at the beneficiary's place of residence, when delivery of services has actively begun.

Since the time counted must be actual treatment time, providers are expected to discount time spent on non-treatment related interruptions during the in-home visit. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service time.

In-home time represents only a portion of the total time invested by an agency in caring for a patient. Numerous activities required by the Medicare Conditions of Participation and needed to ensure effective patient care are often performed outside the home, including communication with physicians and family members, coordination of services with other home health personnel and community agencies, care planning, and clinical documentation. In order for home care treatment time to be meaningfully quantified, visit time must be better defined and recognized as only part of the resource cost involved in providing home care services.

Neither Congress nor HCFA has indicated how this information will be used. Its value is questionable in light of the ongoing move from a cost-based reimbursement system to a prospectively set per-episode payment that is not tied to number of visits or visit length. In light of the substantial financial and administrative strains already being experienced by agencies, we urge you to revisit this requirement.

2. THE OUTCOME AND ASSESSMENT INFORMATION SET (OASIS) REQUIREMENTS

NAHC has long supported the use of a uniform data set for collecting data and measuring, and ultimately improving, patient outcomes in home care. Over 10 years ago, HCFA proposed the development of the Outcome and Assessment Information Set (OASIS), a data set aimed at accomplishing these goals. NAHC has demonstrated its support of OASIS development and use for outcomes measurement and quality improvement in its educational programming and publications.

More recently, HCFA determined that OASIS data would be useful in development of a case-mix adjuster for a home health prospective payment system (PPS).

While NAHC acknowledges the many benefits that may accrue from OASIS, we continue to believe that several actions must be taken before home care providers can adequately undertake OASIS data collection and reporting requirements.

HCFA has seriously underestimated the costs of OASIS-related requirements with respect to:

1. Initial start-up (hardware, software, clinical and administrative staff training);
2. Data collection (additional time required for patient assessment and reassessment, printing and supply costs);
3. Transmission of OASIS data; and 4) the willingness of third party payers to share in the burden of OASIS start-up costs.

Home care providers have reported that it costs them from one to three dollars per visit to comply with the requirement, whereas HCFA has allowed only three cents per visit by way of reimbursement. Further, reimbursement is tied to per-visit cost limits. Only agencies that have not already reached the per beneficiary limits will benefit from the per-visit adjustment; HCFA estimates that about 70 percent of agencies will not receive an adjustment for OASIS costs. There has been no adjustment in the per beneficiary limits to address the increased costs of OASIS. Agencies are unable to absorb the costs of OASIS, given that over 90 percent of agencies are being reimbursed less by Medicare than their actual costs of providing care and, on average, home health agencies are receiving 30 percent less in reimbursement than they were prior to implementation of the interim payment system in October 1997. In addition, third party payers are unaware of the value of OASIS and are unwilling to compensate agencies the additional cost of OASIS implementation, data collection and reporting.

Under legislation passed in 1999, Congress acknowledged that agencies incur significant new administrative costs due to OASIS requirements and mandated a one-time \$10 per patient payment in 2000. While this additional payment provides some assistance and is greatly appreciated, the major portion of OASIS costs remains unreimbursed.

By way of comparison, in 1987, HCFA increased the home health cost limits when changes were made to the forms for home health agency (HHA) billing and verification. This series of forms is known as the 485 series as it encompasses today's plan of treatment, the medical information form and the medical information request

form (485, 486, 487, and 488). In establishing reimbursement rates, HCFA was required to take into account the cost of this new series of forms by increasing the base limit values for per-visit reimbursement to the HHAs beginning July 1, 1986, by \$.37, and by \$.39 in 1987 (52 Federal Register 25562, July 7, 1987). The average cost of all Medicare home health visits in 1987 was \$48. The OASIS paperwork burden is greater than that imposed by the 485 series of forms. But even performing a simple projection of the 485 series add-on for 1987 to OASIS in 1997, the increase to HHA reimbursement by HCFA would be, at a minimum, \$.61/visit.

NAHC believes that agencies should be reimbursed the full costs associated with meeting OASIS requirements. HCFA should conduct further study regarding costs of OASIS and adapt its reimbursement structure to reflect the real costs agencies are incurring. If HCFA lacks the authority to adjust the per-beneficiary limits, Congressional action should be taken to empower HCFA to make the necessary adjustments. HCFA and the Congress should also ensure that rates of payment under the forthcoming home health PPS reflect the costs of OASIS. HCFA should allow agencies adequate time to ensure payment from third party payers that will cover the cost of meeting OASIS requirements for non-Medicare, non-Medicaid patients.

HCFA has determined that OASIS data must be collected and transmitted for all patients receiving skilled and/or personal care services, regardless of payer or patient health status. This determination has added substantially to the regulatory burdens under which home health agencies are currently operating.

NAHC believes that OASIS data collection requirements should be limited to Medicare and Medicaid patients who are receiving intermittent skilled services.

Patient privacy rights remain a serious concern throughout the country. OASIS represents a vast collection of patient information that, if used inappropriately, could cause great harm to patients. Additionally, patients may be at risk of not receiving needed care if they refuse to supply specific information or provide approval for the release of this information.

NAHC believes that HCFA should develop privacy protections such that patients are assured that confidential medical information will remain confidential. These protections should include the development of encryption software by HCFA before transmission is required for non-Medicare, non-Medicaid patient OASIS data. There should be no transmission of patient-identifiable information by a home health agency without the written consent of the patient. No patient should be refused services on the basis of an unwillingness to consent to the transmission of confidential information.

3. MEDICAL CLAIMS REVIEW/SEQUENTIAL BILLING

Home health providers are experiencing increasing difficulties in processing claims through the fiscal intermediaries (FI) for services provided to Medicare beneficiaries. Problems cited by agencies include increased inappropriate and excessive random and focused medical reviews, medical review inconsistencies, technical denials, and sequential billing.

A wide variety of inconsistencies exist in payment decisions by the FIs reviewing medical claims. Differences in interpretation of homebound, technical requirements, and medical necessity requirements have resulted in confusion among many home care providers. In addition, local medical review policies are often more restrictive than the coverage policy dictates, complicating coverage decisions further.

In response to a growing Medicare home health program, HCFA earmarked increased funding for medical review activities which have increased random and focused medical reviews, targeted audits, and fraud and abuse initiatives, such as Operation Restore Trust (ORT) and Wedge audits. Providers thought they would receive relief from medical review levels ranging from 25 percent to 100 percent when they received a HCFA letter stating that no more than 10 percent of a provider's claims would be subject to random review edits. At HCFA's urging, however, FIs have instituted other types of medical review edits. As a result, agencies are being subjected to multiple edits at one time, slowing payments significantly and exacerbating financial difficulties for providers. In addition, many of the denials issued as a result of medical review are for technical reasons which have no bearing on patient's eligibility or delivery of medically necessary services.

HCFA instituted the sequential billing policy to ensure proper allocation of home health expenditures to Medicare A and B. This has meant that home care agencies have not been reimbursed for services recently given to a Medicare patient if there are any outstanding claims, or if a dispute exists over previous services offered to the same patient. NAHC and others have worked since early 1998 to convince HCFA to suspend its sequential billing and payment policies on the grounds that they were unnecessary and caused harmful cash flow problems for financially

strapped home health agencies. Although HCFA ordered a halt to sequential billing in July 1999, the repercussions of this ill-advised policy have continued for some time. Agencies have missed payroll and further damaged their fragile credit ratings.

Given the current financial uncertainties related to intensified audits and disallowances and inconsistent medical reviews, thousands of Medicare claims are currently in dispute or on appeal. This has created severe cash flow problems for many providers. Agencies are under severe financial hardships when payments are delayed weeks or months while under review and appeal.

4. SURETY BONDS

BBA97 mandated that all home health agencies participating in Medicare and/or Medicaid secure a minimum surety bond of \$50,000 in order to protect the programs from fraud. HCFA published implementing regulations that went far beyond the intent of Congress. In the wake of overwhelming Congressional objection HCFA withdrew its regulations and agreed to develop new regulations.

The House Government Reform and Oversight Subcommittee on Human Resources released a report highly critical of the HCFA and its handling of the BBA97 surety bond requirement for home health agencies. The report describes HCFA's surety bond rulemaking process as "inadequate" and "technically flawed;" HCFA, for the most part, did not take into account recommendations or technical expertise offered by the home health and surety bond industries. Similarly, the Small Business Administration (SBA) filed a petition to HCFA that was extremely critical of the agency's process in developing the surety bond regulations. In part, the SBA stated that the agency "changed the rule into a vehicle for punishing legitimate HHAs and for securing overpayments to Medicare rather than a vehicle to discourage bad actors from entering the Medicare program."

It appears that throughout the regulatory process there has been a significant lack of understanding of surety companies' practices, the principles behind surety bonds, and their uses. HCFA should establish surety bond regulations in accord with the intent of Congress—as a vehicle to keep "fly-by-night" operators from participating in the Medicare program. Last year Congress acted to bring more reason to the surety bond requirement for home health agencies by limiting the requirement to the lesser of \$50,000 or 10 percent of Medicare/Medicaid revenues, to a single bond for Medicare and Medicaid participation, and to 4 years duration. Additional changes that would make the requirements more reasonable follow:

1. The bond should not be used as a vehicle to recoup overpayment, but rather as a means to ensure that an agency does not pose an unreasonable risk to the program.

2. As the bond requirement is a condition of Medicare participation, it should be reimbursable.

3. Agencies that have proven track records in the Medicare program should not be required to purchase bonds on a continuing basis.

4. Statistical sampling methodology for post-payment review

In March 1999, HCFA published an FI manual update outlining new procedures for comprehensive medical review using statistical sampling (Transmittal Number 1770). The updated instructions provide details for conducting comprehensive medical reviews, medical review audits, and for statistical sampling and overpayment projections.

The use of sampling procedures involves the FI identifying a specific portion of claims from among an agency's claims submitted during a specified period of time. The proportion of denied claims in the sample would be extrapolated to all claims for the period, resulting in denial of claims that were never reviewed individually.

Sampling imposes significant risks to agencies and eliminates some provider's appeal rights. Under HCFA's sampling policy, the overpayments projected through the claims reviews are recouped by Medicare prior to any rights of appeals. Since the projection can involve millions of dollars, home health agencies are unlikely to survive long enough to access the appeals process. Appeals are important because reversals of claims have routinely exceeded 80 percent over the years.

The HCFA Region V Associate Regional Administrator registered a protest alleging that the statistical methodology used is invalid and irresponsible. This claim is supported by the Region V statistician and the statistical consultant to the Department of Justice in Chicago. Documents have been submitted to this committee regarding this allegation. With an improper sampling methodology the risk of erroneous overpayment projection is dramatically heightened.

HCFA has rejected the majority of recommendations made by home care providers to stop sampling and overpayment projections. In addition to opposing the use of statistical sampling, NAHC objects to the manner in which HCFA implemented this

policy. At a minimum, policy changes of this nature should be subject to public review and comment as required under the Administrative Procedures Act, before it is finalized. NAHC recommends that HCFA suspend its instructions to the FIs on statistical sampling of home health claims until appropriate modifications are made in policy.

5. BRANCH OFFICES

HCFA has established new criteria for branch offices that emphasize the distance of the branch location from the parent without reasonable consideration of the parent entity's actual supervisory capabilities. The policy does not recognize the use of modern methods of communication such as faxes, telephones, pagers and telecommunications that are used by every other business in the country as acceptable methods of communication and supervision. HCFA's branch office policies are contrary to regulatory reform initiatives and the proposed conditions of participation which espouse the need to change from structure-based requirements to a focus on outcomes and quality of care. In many cases agencies have closed branch offices because of the added costs of complying with the conflicting and unnecessarily restrictive branch office policies, producing access problems for beneficiaries. NAHC drafted a petition for rulemaking on behalf of Medicare certified home health agencies, requesting HCFA to institute a new rulemaking procedure and establish a single set of national criteria for defining "branch office" of a home health agency under the Medicare program. After over 2 years, HCFA has failed to respond to this rulemaking petition.

6. PHYSICIAN REFERRALS

The "Health Insurance Portability and Accountability Act of 1996" (Public Law 104-191) included a provision that imposes severe civil monetary penalties on any physician who certifies a patient as eligible for the Medicare home health benefit who does not meet the eligibility requirements. This has produced a chilling effect on physician referrals. Although the statute limits liability only to those cases where the physician "knowingly" certifies an ineligible patient, HCFA has created such an environment of fear with its overzealous anti-fraud campaign that doctors are afraid to refer patients for home health services. NAHC has received numerous reports that for many patients this is limiting access to home health services for which they are, in fact, eligible.

HCFA has not adequately informed physicians of their role, coverage criteria, and clear definitions of the terms "homebound," "medically necessary," and "skilled care." In order for physicians to take an active and responsible role in ordering and gatekeeping home health services, they must be fully informed of the breadth of the benefit and eligibility requirements.

7. ITEMIZED BILL ON DEMAND

The BBA97 required that home health agencies provide patients with an itemized bill on demand. The staff time and computer programming required for this is an additional cost not accounted for in setting both the per visit cost limits and the per beneficiary limits.

As mentioned previously, Medicare will move to a prospective payment system for home health in October. We in the home health community have great fears that the payments made under the new system may be inadequate to care for some patients, particularly those patients that are in need of high cost care. The budget for spending under the new PPS is limited to what would have been spent if the current IPS system remained in place. Further, individual payments under the new PPS are based on data from 1997 that fails to take into account a number of costly regulatory requirements that have been imposed since that time. Following is an analysis developed earlier this year by NAHC outlining some of these regulatory requirements and their impact on home health agencies. We urge that Congress give serious consideration to increasing the allowable budget for the first year of home health PPS to help account for some of these increased costs that have not been included in the PPS base rates.

1997: ELECTRONIC COST REPORTING

HCFA initiated a requirement for electronic cost reporting for home health agencies. Prior to that point, home health agencies submitted cost reports either on paper or electronically.

IMPACT

Home health agencies were required to purchase necessary hardware and software to prepare and transmit electronic cost reports. Where agencies were unable to internally develop the capabilities for electronic cost reporting, outsourced services had to be acquired.

SITE OF SERVICE BILLING

Under the Balanced Budget Act, home health agencies were required to modify billing practices to submit bills based upon the site of the patient as compared to the previous long-standing practice based on the site of the health care provider.

IMPACT

Home health agencies had to significantly revise billing practices and supportive software to accommodate service provisions outside of a single wage index area. In particular, home health agencies with branch offices in MSAs or geographic areas distinct from the parent location had to adjust billing practices.

1998: IMPLEMENTATION OF INTERIM PAYMENT SYSTEM

BBA 1997 dramatically changed the reimbursement system for Medicare home health services, establishing a new annual, per beneficiary payment limit. Previously, home health agencies were subject only to a per visit cost limit.

IMPACT

Management and operations systems had to be significantly modified to accommodate the monitoring of per patient costs, patient census calculation, and financial forecasting for annual patient care within the per beneficiary payment limit. Financial, clinical and operations staff required intensive education to understand the new interim payment system. Computer hardware and software adjustments were required to secure, maintain, and manage the data for program administration.

IMPLEMENTATION OF SURETY BOND MANDATE

In accordance with BBA 97, HCFA issued regulations on January 5, 1998 requiring all home health agencies to secure a surety bond for Medicare and Medicaid purposes. While the surety bond requirement was ultimately suspended pending Congressional review, home health agencies were required to undertake the effort to secure the surety bond until the ultimate postponement.

IMPACT

Compliance with the surety bond requirement necessitated efforts by home health agencies to gain an understanding of the surety bond marketplace, evaluating potential supply sources, and undertaking the application process. The application for a surety bond requires a home health agency to develop and present detailed financial information regarding the status of the agency, background information regarding principals associated with the home health agency, securing an independent financial audit, and the bond cost itself.

MULTIPLE CHANGES IN BILLING REQUIREMENTS

1. SEQUENTIAL BILLING

In the early stages of 1998, HCFA concluded that it needed to modify the time frame for billing of home health claims in order to accommodate the switch of a portion of the Medicare Part A home health benefit to Medicare Part B. HCFA required that home health agencies bill claims in sequence which meant that a home health agency had to hold a claim for a month of services if the previous month's claim on behalf of the same patient had not been fully processed. The sequential billing requirement was not withdrawn until 1999.

IMPACT

Home health agencies were required to completely alter billing systems to accommodate the sequential billing requirement. Systems had been designed to bill on a periodic basis provided that all of the technical elements for completing the claim were met. With the sequential billing requirement, screening and monitoring systems had to be implemented that would hold a sequential claim for an undefined

period of time during the pendency of a proceeding claim. In some circumstances, the processing of the proceeding claim could be delayed for months as it was subject to full medical review. In addition, the sequential billing requirement slowed cash flow necessitating home health agencies to secure financing simply to meet payroll. The system changes and financing responsibilities for cash flow led to high cost for most home health agencies.

2. LINE ITEM BILLING

Effective with services provided on or after April 1, 1998, HCFA required providers to line item date all home health services furnished during a visit. The service date had to be present or the claim would be rejected. In addition, the line item dating limited the claim to 55 items, thereby forcing home health agencies to file additional claims where more than 55 services were provided during that period of time subject to the claim. The line item dating requirement was intended to provide further information to support HCFA's management of the Part A to Part B shift of the home health benefit.

IMPACT

Billing software and operation systems had to be modified to gather the necessary date related information, transmitted to billing operations, and properly record these services dates on the billing forms. The transition to this process forced home health agencies to incur significant costs to acquire revised software, educate staff on the new requirement, and monitor compliance.

INSTITUTION OF HOME HEALTH AGENCY PARENT, BRANCH AND SUBUNIT CRITERIA

In August 1998, HCFA issued a Program Memorandum that consolidated and clarified guidelines for distinguishing between branch offices and subunits of parent agencies. While HCFA may have considered its Program Memorandum to be merely a clarification, it entirely changed the standards that had been previously applied. With the "policy clarification" HCFA turned its primary focus to the distance that a home health agency branch was located from its parent in terms of time and/or miles. In many of the HCFA regions, a home health agency was precluded from maintaining a branch if the site was located more than 1-hour or more than 60 miles from the parent location. As a result, several thousand home health agencies were forced to either close branch office sites, relocate the sites closer to the parent, or transition the site to the subunit status. A subunit home health agency must demonstrate that it independently meets the criteria for participation in the home health agency without services from the parent. A branch does not have to independently meet the Medicare conditions of participation.

IMPACT

The cost of transitioning to subunit status, closing a branch, or relocating a branch can be measured in several ways. A subunit must have its own administrator, governing board, professional advisory committee, system of personnel and patient records, billing system, and cost reporting. Relocation costs of a branch to more proximate site to the parent, could involve higher space costs, moving expenses, increased costs for staff travel to patients, and potential penalties for early termination of a property lease. The closure of a branch generally would lead to a reduced volume of patient visits, thereby increasing the unit cost of service as fixed operations costs were allocated to a smaller universe of visits.

INSTITUTION OF A CORPORATE COMPLIANCE PLAN

While institution of a corporate compliance plan conforming to guidelines issued by the Office of Inspector General is voluntary, the OIG and others have strongly encouraged home health agencies to implement a detailed compliance monitoring system.

IMPACT

A comprehensive corporate compliance plan involves intensive administrative and management responsibilities. Internally, cost reporting and claims auditing system must be created, implemented, and managed. Staff education and direct leadership involvement are crucial to a compliance plan. The value of a corporate compliance effort is significant and direct to the Medicare program as claims error rates under the home health benefit have dropped dramatically.

1999: OASIS IMPLEMENTATION

Effective in June 1999, all Medicare and Medicaid home health agencies were required to conduct an OASIS assessment on all skilled care patients and electronically transmit the assessment to a centralized database within each state. The assessment was required for all patients; reporting is currently required for only Medicare and Medicaid patients. It is expected that HCFA will release patient identity encryption standards that will lead to the expansion of the reporting requirement to all skilled care patients regardless of payer source.

IMPACT

Home health agencies were required to engage in an intensive alteration of their patient assessment operation. The changes required included staff training, installation of performance monitoring systems, acquisition of software, creation of electronic transfer capabilities, and increase of data input resources. Many of these changes require expenditures both initially to establish the OASIS system internal to a home health agency and on an ongoing basis to maintain compliance. In addition, home health agencies are responsible for allocating significant additional nursing and therapy time to complete the OASIS assessment thereby increasing the average cost of a visit.

15-MINUTE INTERVAL BILLING

As part of the BBA 1997, home health agencies are required to submit home health service bills with the reference to the number of 15-minute intervals of face-to-face care time in each of the billed visits. The 15-minute billing requirement was instituted by HCFA effective for all bills after October 1, 1999.

IMPACT

Home health agencies were required to modify all billing processes to accommodate the 15-minute billing standard. Staff was required to record, in an auditable fashion, the actual face-to-face time in service to patients. This recording had to be translated to the number of 15-minute units. Billing formats and data inputs to support the formats required adjustments to meet the standard. As a result, increased service staff time, administrative staff time, and supportive software was required for compliance.

MEDICARE CLAIMS REVIEW

During 1999, HCFA increased its efforts in review of home health claims. These reviews took a variety of forms including prepayment claim review subject to the intermediary edits-focused medical review targeting certain providers or types of claims, comprehensive medical review of claims on a post-payment basis, and the use of statistical sampling for overpayment estimation.

IMPACT

While HCFA has full authority to engage in claims review, the increased volume of claims reviews combined with the variety in methods of claims review have significantly altered administrative responsibilities within a home health agency. Medical review requires home health agencies to allocate management, field, and support staff resources to responding to a claim review. These responsibilities range from processing the claim review request, securing and copying the requested patient records, forwarding the records to the intermediary, and monitoring the claim review results from a financial perspective. In addition, field staff resources are required for internal analysis of the claim compliance along with management staff resources to coordinate all activities related to claims review within the home health agency. Claims review also impacted on cash flow and necessitated borrowing to meet ongoing financial obligations such as payroll.

BENEFICIARY NOTICES

In 1999, HCFA issued instructions regarding the notices that home health agencies must provide the home health beneficiaries in advance to furnishing what home health agencies believe to be non-covered care, reducing, or terminating ongoing care. In addition, the instructions set out the process required for submitting bills to Medicare when the patient demands that a provider of services submit a claim for care which the home health agency believes to be non-covered.

IMPACT

Home health agencies had been using a HCFA model beneficiary notice that had been issued by HCFA in the early 1980's. The new HCFA instructions recommend using a series of three model notices to replace the single notice previously in use. In addition, the one page model notice was revised into a complicated four-page notice. It is also necessary for home health agencies to secure a written acknowledgment of receipt of a notice from the beneficiaries.

Home health agencies are required to replace existing notices with the recommended new model notices. This effort required a combination of efforts to compose the new notice to properly identify the particular home health agency along with obtaining printed notices for use with patients. Home health agencies had to engage in staff training efforts to familiarize them with the new requirements related to the notices and the demand billing process. Quality assurance monitoring systems had to be established to ensure compliance. Finally, increased staff time was required to respond to the numerous inquiries that came from beneficiaries who uniformly expressed an inability to understand the new model HCFA notice.

Y2K COMPLIANCE

As with other businesses, private individuals, and the government, home health agencies were required to undertake efforts to ensure that their computer systems were Y2K compliant prior to the close of 1999. Home health agencies are significantly reliant upon computerization for clinical record keeping, billing, and virtually all other aspects of their operation.

IMPACT

For some home health agencies, Y2K compliance meant a purchase of new hardware or software. At a minimum, home health agencies had to undertake a full assessment of their information technology capabilities and Y2K compliance.

Thank you, Mr. Chairman, and Members of the Task Force, for the opportunity to present our views on Medicare's regulatory impact on patients and home health providers. Your efforts to recognize the costs of new administrative requirements upon home care providers and your actions to ease the regulatory burdens can go far to stem the crisis in home health. Your actions can help ensure that the PPS is established on firm financial footing and provides access to countless eligible beneficiaries that might otherwise lose access to needed home care services.

Chairman CHAMBLISS. Let me just start off by asking Dr. Robinson, we have been involved in Medicare now for 35 years. Obviously, I think when you started practicing, Medicare was on the books and being implemented. But if you will take a minute to tell us what differences you have seen in the complexity of dealing with Medicare, particularly from a regulation causation standpoint over the last 20 years in your medical practice.

Dr. ROBINSON. Well, I think there has been a cultural shift, if I could say that, in the practice of medicine. When I commenced my medical practice, it was—I think the idea that a physician would know the patient's insurance status and would know anything about the compensation or billing issues that would be involved in a particular kind of patient, that was an anathema. It was a very unseemly thing to do. And there was—I think that served the patient's interest to have it that way.

And what has happened since that time is that this morass of regulations and coding issues and potential prosecutions has totally transformed the circumstances of health care delivery, and it is a very unwelcome intrusion and I think it has had a negative impact on patient welfare.

Chairman CHAMBLISS. Let me ask the same question to Ms. Murray and Mr. Vaughan, if you have any comments that you can make on that same issue.

Ms. MURRAY. I would agree absolutely with Dr. Robinson's comments. I was sitting here thinking about examples in hospitals. For

example, when Medicare started to reimburse for observation care, we needed patients to stay in the hospital for maybe a day after a certain procedure or certain surgical procedure. Medicare said, here are the rules regarding observation care, here are the rules regarding inpatient care. And we started classifying patients rather than thinking about how long do they actually need to be in the hospital. We were thinking about what is the right reimbursement format and how do we code these patients, et cetera.

Right now there is a conflict between the PRO and HCFA on observation care. HCFA rules—or our intermediary for HCFA rules has stopped paying patient for observation care and told us to classify these patients as inpatients. The PRO, however, denies these patients as inpatients because they don't meet the inpatient criteria established by PRO. Again, our choices are don't take care of the patient, which of course we couldn't do, or take care of the patient without reimbursement which is exactly what we have been doing for some time now on observation cases.

The other major concern obviously is the tremendous additional administrative burden in the over 100,000 pages of Medicare rules and regulations. We try to shield our staff taking care of patients from this problem, which isn't so easy in a physician's office. And it isn't always easy on the day-to-day basis if you don't have sufficient administrative staff to do all these things, as in the case of Mr. Vaughan. But in our case, all we do is add costs and that has been a major problem for us over time.

Chairman CHAMBLISS. Mr. Vaughan.

Mr. VAUGHAN. Yes, sir. Again, I would agree in full. The changes I have seen that are the most burdensome, again, are the paperwork requirements, much more advanced coding. It is very difficult, very nebulous; also, to a large degree, really interferes with your ability to treat a patient. As an example, the laboratory having to have the exact codes for the diagnosis prior to the diagnosis essentially being made for the patient. A lot of that is exploratory and a person is coming in with lab work, say, for an outpatient testing procedure, it ties up the process of us being able to get that patient in quickly, possibly for surgery. A lot of things today involve a much more complex system of reimbursement than it was years ago when I first started out. And the talk many years ago, again, was simplifying the system, but I have not—I can't think of any simplification that I have seen in what we do. The complexity level now is at a point that regardless of size of a hospital or a physician's office or any other providers, it is nearly impossible to comply.

I think you will find that the industry, while there are problems—and I know a large part of this hearing today involves compliance and actual regulatory measures there, are very important. Most of the providers in this country want to be complaint with the law, make every extra effort possible. Again, you are dealing with small offices and small hospitals, and, again, even large hospitals have the same difficulties when you make the regulations very difficult to interpret. Again, it is that Catch-22, as was mentioned, it is a formula for disaster. I think that the true—essentially people that are breaking the law need to be identified. They are the ones that need to really be burdened by these things.

On the other side of the coin, the efficient providers of care are the ones that should be rewarded, those that seek the highest quality and do it most efficiently. The system doesn't do that now. There is no reward for a hospital that runs better than the next, particularly with the evolving legislation that is out there.

Hospitals—again, just as an example, some of my doctors as recently as last week talked to me about the amount of time in their office spent on paperwork, which has gone up as high as 50 percent in some instances. I would estimate my nurses spend 25 percent of their time on paperwork and charting versus actually hands-on patient care. It is probably one of the largest complaints a hospital administrator hears today: That wasn't enough time, really, spent talking to my mother or my father. You provide good care but you don't have enough nursing staff. It is essentially a lot of things are taken away of why that patient is really there.

Again, our organization seeks to be the highest quality. We were recently surveyed by the Joint Commission and scored extremely high. We put the effort in, we achieve the things we want to achieve, not because we are required, but it is so much more difficult these days. And that is my overall feeling. I have been in hospital administration about 15 years and it is vastly different. At some point along the way I thought it would probably improve and things would level out to a degree, but at this point it has gotten almost to a destructive nature.

Just by chance I picked up the Savannah News. I have only been in Georgia one week—and this was two days ago, and on the front page here is a hospital in rural Georgia that is closing. In fact, it is already closed. So, again, it is just a good example. The smaller hospitals, less than 50 beds, are really up against the wall.

Chairman CHAMBLISS. Thank you. We have got one other change in schedule that has just come about. The folks that have the room at 12 o'clock are going to be through at 1 o'clock. We are going to break now and instead of coming back and rushing through a few questions, if you all could come back at 1 o'clock, we will start again. Before we break, Mr. McDermott has a comment.

Mr. MCDERMOTT. I have just one question or one request of you. You have 2 hours which we didn't know you were going to have. If you would sit among yourselves and write down the 10 things, if you had your wish list, that you would have done. We will give you 2 hours to think about that. This is a blue book challenge.

[Recess.]

Chairman CHAMBLISS. We appreciate very much your patience. And I am sorry instead of 1 it is 1:15, but hopefully we will be able to complete this hearing without any more interruptions. I am not sure how many of our folks will be able to come back. I have talked to a couple of them, who said they were not going to make it back, that asked me to raise a couple of questions and ideas which we have previously talked about. I will let Mr. McDermott get to his David Letterman Top 10 List when he gets back.

You know, in dealing with some other Federal agencies, particularly those that have service within their name, we find that those organizations who are supposed to be service organizations from the Federal Government standpoint are really not service organizations. They are more organizations that tend to try to wield a

heavy hammer rather than trying to help people out, even though they are intended to be a true service agency. And I am wondering if we have that in Medicare.

For example, if you have a situation in your office that you are unsure about, whether it is legal, ethical, or whatever within the rules of Medicare, is there anybody you can pick up the phone at Medicare and call and say hey, this is a situation that we are facing; we need some guidance and we need some help in establishing a program or making sure we are doing the right thing. What has been your experience that that respect?

Ms. MURRAY. If I can start, you know we work through Medicare intermediaries who are the organizations that we work with to clarify Medicare policies and to make our payments, et cetera.

Medicare intermediaries can change. And for us, for example, our Medicare intermediary changed recently and we now have 30 new policies that came out from our intermediary to guide their requirements for our payment. They happen to be different from the physician intermediary policies. So there is some conflict between the two sets of policies.

We are required to go to the intermediary for questions and it is often very difficult to get clarification from the intermediary. For example, there are hospitals who are occasionally overpaid by Medicare. And we know of instances where hospitals who have tried to repay the money through the intermediary and the intermediary will not take the payment. This reflects poorly on the original intermediary processes, et cetera, et cetera.

Hospitals then tend to put that money in an escrow account, hold it, and try to pay it back in some fashion. If, however, they are audited by the Federal Government, they can be accused of fraud for keeping an overpayment from the Federal Government.

These kinds of issues are very difficult to resolve through an intermediary, if not impossible. So it is just an example of some of the difficulties that we have. The intermediaries also interpret the regulations differently on the basis of the intermediary and sometimes on the basis of the individual that you talk to with the intermediary on any given day. And that also makes the situation even more complicated.

Chairman CHAMBLISS. Do you ever get to anybody at the grass-roots level of Medicare who is making a decision up here at the top, or do you strictly have to deal through the intermediary?

Ms. MURRAY. We generally deal through the intermediary. I can't answer specifically if we have ever gotten through our finance office to somebody else, but generally we have to deal through the intermediary.

Chairman CHAMBLISS. Anybody else?

Mr. VAUGHAN. I would agree with Kathleen's statement. It is pretty much the same, but again it would be a possible solution to have the parties get together. The intermediary has always been the middle and it is not like you have a local representative that you can discuss any situation with really. But if that would be a possibility in the future, it would be something worth looking at if you have an issue or problem that can really be worked out on a more local level, but the system is not designed that way currently.

I don't think it is anybody's particular fault right now; it is the system design that we have.

Chairman CHAMBLISS. Apparently that kind of problem must not be an uncommon problem, because in some reading that I have done I have seen where folks have had some—for some reason, the figure 11.80 has appeared in three different examples, and I guess that is coded to something. And they wound up spending thousands and thousands of dollars in legal fees and accounts fees plus their time in trying to get it resolved. Maybe that is something that we can look at on our end to establish some sort of direct line of connection between you all and HCFA.

Dr. McDermott is back with us. I told them I was saving your Top 10 David Letterman issues until you got back here. So I know you have got to leave. I will give you the freedom to take care of whatever.

Mr. MCDERMOTT. First of all, I have a couple things to say. One is that you must not be doing too bad a job, since I understand Medicare pays 95 percent of the clean claims without any questions. So we are talking about 5 percent of the claims that they are questioning or at least that is the way it looks to me. And I wonder if I could ask a question of the two doctors. If you order a chest x-ray, shouldn't you be able to put down a diagnosis that might be related to that chest x-ray? Now when I was a medical student we used to have kind of standing orders; we just ordered a chest x-ray on anybody whether or not the issue was related to the chest. And I suspect there have been hundreds of thousands of chest x-rays done that were not useful in terms of diagnosis.

So what I am interested in is wondering if you—I mean, I picked this because it is the one specific you gave me. You said lab tests are being held up because there is no ICD9 code. If I am going to do a chest x-ray, I probably am looking for something in the chest. And if I put down carcinoma of the lung, because that is what I think it is, and it turns out to be bronchitis, that is not going to invalidate my claim, is it?

Mr. VAUGHAN. That is directed to me. First of all let me state I am not a doctor, but I will try to answer your question. My understanding from the physicians on our clinical staff, again, is—and your point is valid, I understand what you are saying, but the regs are nebulous as it stands. If, say, that diagnosis turns out to be a false negative, say, it doesn't exist, say, will that claim be paid or not and does the patient indeed have the responsibility? So again, it is—these are new regs and they are very difficult to interpret.

In the past, you know, it wasn't the type of system we had. Again, it is—I think people agree with the intent and, again, waste in the system and so on. But it is a little bit more front line right during the time that you are practicing medicine as a physician and the hospital is trying to respond by offering you the test that you need. And it is kind of in the way right now—the way people are interpreting the regulations.

Again, my statement would be that they need to be looked at, they are coming on real fast, and very few people are having a chance to understand the regulations and really operationally put them in place, because you are talking about many, many thousands of contacts just in a small hospital with the lab and x-ray

and ultrasound and other things. Laboratories are particularly complex due to the multitude of tests and the diagnosis lining up with the test. But, again, I am speaking not as a physician but as an administrator.

Mr. MCDERMOTT. Your response, Ms. Murray.

Ms. MURRAY. I would agree with what Mr. Vaughan has said. I think the fear that Dr. Robinson mentioned of potential fraud accusations contributes to this problem, too. So if you are a physician and the hospital says you know you've got to put in ICD9 codes, which by the way is an inpatient diagnostic code, in there before you order these three lab tests, they are going to say, well, I don't know what the diagnosis is. And if I put something down that is wrong, I might be accused of fraud in the future.

So the physician is in a position of having to supply information that he doesn't necessarily have, even if he might have a rule-out diagnosis, which is not acceptable anymore. Then he has got to put some diagnosis down, might be wrong, fears fraud, doesn't want to do it, comes to the hospital without the diagnosis; hospital fears fraud, doesn't want to do the test. And, as I say, we are doing the test, sometimes we are going back retrospectively trying to get an ICD9 code once the patient has the diagnosis information they need. But that is not what the law requires, the regulation requires the code in advance.

Mr. MCDERMOTT. When was the rule-out diagnosis made invalid?

Ms. MURRAY. I can't answer that question. But I am told that the old, more general, ICD9 codes are no longer acceptable. It was recent but I am not sure when.

Mr. MCDERMOTT. The issue, I guess, you can see it from our side, that if somebody has a lab in their office and they want to run everybody through, no matter whether or not and charge \$15 a crack, they can have a good time making a lot of money but not doing anything for the patients. Obviously no one wants to deny the test for the patient who needs it, but the question is how do you determine where some people do a urinalysis on 100 percent of the people who come through their office and some do it on 20 percent, the question at least could legitimately be raised, couldn't it?

Ms. MURRAY. I absolutely agree that there is an issue there. I would go at it more from a variance reduction in quality standpoint and perhaps look at self-referral—there is a strong look being taken at those kind of things. But I think what we have done instead of going after, say, the 80/20 rule in the areas where there is self-referral or where there is a variance from standard, is we have just taken a broad brush and penalized everybody and caused a problem in actually giving care.

Mr. MCDERMOTT. Dr. Robinson, you raised the issue of fear. I don't know how you write rules and regulations without putting the fear of God in people, do you?

Dr. ROBINSON. Yes.

Mr. MCDERMOTT. OK, tell me how.

Dr. ROBINSON. Well, I think the first thing is to, I think, consider exactly what kind of conduct you are attempting to moderate. And so if the conduct that you are attempting to moderate is merely a misunderstanding of the billing codes—and that is not an appropriate area in which an American citizen should fear his govern-

ment—some dispute over the nuance of a billing code when there is a motivated practitioner attempting to do something. So there should not be any criminal penalties, there should be no sanctions attached to that type of dispute. There shouldn't be any sanctions attached to it.

Those behaviors that I think every ethical physician recognizes is egregious and wrong and bad, I think would be important to identify that particular cohort of people that behave that way and I then I think try and particularize the demographics of where these abusive procedures have occurred, and then that is the place to place sanctions. And also I think it would be important to try and cooperate with physicians to accomplish that.

I think it would be an important step forward in this whole debate to accept the idea that physicians are on the same side as the objectives of the government in many ways. They want cost reduction, they want quality of care. The problem is if the government or HCFA treats them as presumed to be guilty of some kind of fraudulent behavior, it minimizes their contribution to this process. So that would be one suggestion I would have.

Mr. MCDERMOTT. So you think that if the doctors felt they were part of the process, they don't—your medical association doesn't make input into the rules and regulations, they don't make comments during the rule period?

Dr. ROBINSON. Well, you know I am speaking from the point of view of a person at ground zero. There is a whole apparatus that exists in Washington. And when I leave here I am going to go back to my vineyard and do my best for my patients, and I will leave the apparatus here. But as far as I can tell, the perception of physicians out in the provinces, if I can say that, is that they have very little ability to influence HCFA policies. HCFA policies seem to just be propagated by some distant czar and they are coming down upon us, raining down upon us, and there is not the perception that we have any influence on what is occurring. And many times we see things that seem to us to be quite outrageous, and there is not any easy mechanism that the ground zero physician has to do anything about it.

Mr. MCDERMOTT. Interesting fact about what has happened recently. In the last 4 years you have added 40,000 pages to that pile you described of 130 pages. Thirty of those have come in the last 4 years. So it is increasing. That is a 25 percent increase in a very short period of time. And I suspect that as we have pressed for more and more looking at fraud and abuse, that the result is that you get more rules and regulations. And I am not sure, I would like to hear what you agreed upon as 10 things to get rid of.

Dr. ROBINSON. Maybe I will just start out by saying it is interesting that we had sort of a quick little lunch here. In the course of our quick little lunch—we got a nice Thai cuisine—we came up with 26 different ways to straighten the process out.

Mr. MCDERMOTT. I hope they are written in legible handwriting, by somebody other than you as a physician.

Dr. ROBINSON. We have a very, what can I say, a very nice scribe here who has actually just written them down, and maybe she could start by going over hers.

Ms. MURRAY. Actually he accuses me of being a physician because of my handwriting. So we cannot answer in the affirmative to that question. We tried to come up first with some short-term practical suggestions. And then we have got some medium-term suggestions and then we have a few comments on long term. But let's start for me with the short term first.

We think that if we could have our wish list, which is how we viewed your request, the first thing would be to eliminate the requirement for physicians to submit inpatient diagnosis codes before diagnostic tests are done. Just the subject that you have raised here.

The second would be to eliminate the requirement for patients to fill out the Medicare secondary payer questionnaire at every single time of service. This is really a patient care issue for our patients as well.

Mr. MCDERMOTT. I don't understand why that isn't simply done administratively. What do you think they are trying to get at? If someone is coming up for their next radiation treatment, why do you have to go through that? I would think they would just say to the patient that came into the hospital, would you—are you—has anything changed since we saw you last? No. And that would be the end, and you reprint it.

Ms. MURRAY. That is not my understanding of the interpretation of the rule. I understand what they are trying to get at. Maybe you have acquired secondary payer coverage since you were last seen. And I don't think it was intended to affect patients who are seen two or three times a week, but that is really the outcome of it. Whether we can print off the same form—it has to be signed every time. And if we can print off the same form every time, then we can take it, but some more reasonableness about that rule would be helpful.

In addition, it is now a requirement that the physicians collect the Medicare secondary payment questionnaire for outpatient work that they refer to the hospital. This requires that the physicians do the hospital's billing work. And this is something that just doesn't work. And so this is something else we would love to see addressed.

Fourth, the intermediaries, as I mentioned, sometimes are part of our difficulties. The intermediaries all have something called—they are electronic checks on the claims system. And this is a check that they use to make sure that our bills meet the requirements. We would like them to give us that software so that we can do our checks before we submit the bills so we can submit a clean bill. Now, we have ways ultimately of manually finding out what those electronic claims checks are and then we try to get them into our system, but it would be much easier if we could simply have access to that and we could submit a clean bill that meets the requirement that is what they are looking for.

Mr. MCDERMOTT. What percentage of your billings do you have to resubmit?

Ms. MURRAY. That is a very good question and I am sorry I don't have the answer to it. But I will find out.

If you go to a little bit more medium term, we think that it would be nice to, as the vital statistics organizations have suggested, have one billing system rather than two.

Mr. MCDERMOTT. One billing system meaning A and B?

Ms. MURRAY. Inpatient, outpatient.

We believe that you have some tools at your disposal, including the compliance with—including the Paperwork Reduction Act which also allows for regulatory flexibility for smaller hospitals. And we think that ensuring that HCFA follows the suggestions in the Paperwork Reduction Act would also be a helpful set of activities; and if necessary, use the Congressional Review Act to review regulations that may be beyond the intent of the law. And finally, we just have kind of a general simplicity in the consolidation subject which may get into a long-term approach.

That is my set of lists and then we each have a few others.

Dr. ROBINSON. I hope I can read this, Kathleen. I will do my best. But number 7 was to put in place an outcome analysis apparatus to evaluate the impact of HCFA regulations on health care quality. And I think that is a big deal. Quality. We need to have that in place in HCFA regulations.

Number 8 is a total cost analysis of HCFA regulatory decisions, the total economic impact on individuals, on the community, on enforcement and compliance costs. It shouldn't merely be that the government saves \$2 if it costs society \$10.

Number 9, there should be hearings with doctors at hospitals.

Mr. MCDERMOTT. Let me ask one thing about that because that is something from your testimony. If they deny a \$2 event, and the patient has to pay \$10 out of their pocket, is that what you are talking about? Or are you talking about someplace down the road, the cost of not having dealt with it earlier is more expensive because it was not early diagnosis or whatever?

Dr. ROBINSON. I would say the latter. Often HCFA is exercising a tremendous role in our society. They are making decisions on a bureaucratic basis that have extraordinary economic impact. For instance, if someone is—maybe the regulations don't allow them to get a particular kind of treatment. The treatment is deferred, the patient gets sick, is not able to work, not able to—has to go into a nursing home. That has a very large economic consequence that is past the micromanagement of HCFA regulations. Or a patient is discharged to a nursing home a great distance from the family, and that family has to take—all the family has to get off from work, they have to drive 200 miles. That is an expensive economic event that has transpired against the Nation's interest, all referable to HCFA regulations. So I think that is an approach that needs to be adhered to by HCFA.

Well, number 9 is hold hearings with doctors in hospitals who have been audited to hear firsthand their stories. There are a lot of stories out there that are circulating about very inflammatory events that have occurred. And I think those stories need to be aired, and if there is some violation of good sense that has transpired, the exact causal factors that allowed that to happen should be dealt with. I think that would be a useful hearing to have.

Number 10 is a comment about fraud, and I think it is important to remember. Every ethical physician is against fraud. They think it is reprehensible, it is bad, it is wrong when it happens. And I think an effective way for HCFA to proceed against these cases of fraud would be to isolate those cases that are egregious, they are

obvious, there is just no doubt there is criminal intent involved, and then see in what circumstances those criminals actions occur. What were the demographics of it? Where did this take place? And then concentrate resources on that particular situation.

And there is some kind of 80/20 rule out there, is there not? So if you focus your resources on 80 percent of the problem, you will have a maximum amount of efficiency. So I think that might be a good suggestion.

Number 11 would be to decriminalize billing errors. So there ought to be some sense that—and I think this is an important thing I'd like to stress—is that doctors by their nature, by their training, by their predispositions, are ethical people. They try and do their best in often difficult circumstances. They are not bad people. The regulations are complicated, and it is an appropriate gesture to recognize that and not hold them liable for some coding error.

Number 12——

Mr. MCDERMOTT. Do you have some kind of threshold about that? I mean, I understand what you are saying. And having been a physician and having filled out lots of billings, I understand one can make mistakes. One mistake is certainly not a hanging offense; 2, 10, 500, 1,000, always the same, they have always jacked it up one level. Instead of being a brief visit it becomes an extended visit. If you hadn't had an extended visit, you would have to have seen 20 patients in an hour.

What I am trying to get at is how do you—where do you put the screen for that issue?

Dr. ROBINSON. Well, you know, I would let common sense be my guide. What a reasonable, rational person would say, just looking at the situation, is that these regulations are unbelievably complicated and they are changing all the time. And if there is some kind of just obvious situation where the physician said, look, these new regulations came in, I am supposed to do this, I am supposed to do that, I put a 2 down, I put a 3 down, this is what happens, there should be some way to balance possibly on the other side under coding that occurs.

So one thing that often happens, you have said, we have got this type of conduct where things are being overcoded, probably the more common things are things to be undercoded, because a physician generally in doubt over any of these issues tends to, in my opinion, overcode. That has been my experience. The compensation is not extraordinary. It is a relatively small difference. And most physicians go out of their way to avoid any entanglement with the Federal Government. So I just think common sense would be a guide.

Ms. MURRAY. If I could just add one thing, I don't think it is the number of times it occurred, 50 times 1,000 times, I think it really does come down to intent. For example, there is a hospital recently who had a billing clerk who was consistently checking the wrong box. It was an error. It was a clerk, there was a box, and she checked the wrong box. That hospital, I think, needs to pay back the government whatever they owe them but not pay tens of millions of dollars in fines and penalties because there is an assumption that all of this was done on purpose.

If you have institutionalized upcoding, you have built it into your computer systems, you have built it into your physician capability, they can only check the higher level, that I think is very different and does provide an opportunity for penalties, et cetera. But it isn't a matter of how many times did it occur; it is a matter of how did it occur.

Dr. ROBINSON. If I might just speak—a lot of times what is going on here is the documentation issue. I mean, it is very complicated to know if you are having some kind of coding going on for a service that has been rendered. The evidence of the service being rendered is the documentation of a particular service, if I could say it that way. And the skill and effort that goes into documenting, that is often a major variable in how things work out. But it is not necessarily in the patient's interest that the physician spends his time on trying to placate HCFA.

In other words, if you are sick in the hospital, a physician is putting notes on your chart, those notes should be directed toward your welfare and not these arcane coding regulations or identification about what service has been rendered. I think that is often a confusing issue and it is not—when these coding disputes occur, it is often related to documentation, documentation dispute, which is I think the wrong thing to criminalize.

Well, OK. Number—if I may continue. Number 12 is we suggest that there be an ethical oversight committee to assess HCFA's micropolicies and to make sure those micropolicies are not having a negative ethical influence on patient care. I think we are concerned that there is too much focus by accountants on micromanaging numbers, and that in the culture that is present at HCFA, that we are concerned that the patients may be penalized. There may be ethical lapses that are occurring.

For instance, if a patient is—the numbers shake out a certain way in the coding and the patient is denied appropriate care—there needs to be some kind of overview attached to that; or if these micropolicies are sabotaging physician independence or causing an erosion of the quality of people that go into medicine, if that is what is happening, there need needs to be a mechanism in place for HCFA to take a look at that. So we think that might be a good idea.

Mr. MCDERMOTT. Sort of a patient's bill of rights.

Dr. ROBINSON. I certainly think that is not a bad idea.

Mr. MCDERMOTT. Or a doctor's bill of rights.

Dr. ROBINSON. The two are the same. I would like to think they are the same. It is not that physicians—they are the agents of the patients. Their attention is focused on the patients. I think the two are the same.

Let's see. I have now—we put this one in, our 13th one is there are a lot of individual parts of medicine that are having a negative—being negatively impacted by HCFA. And we considered mentioning neurosurgery but we elected to mention psychiatry, just to throw a pitch at you. But one of the things that goes on is that frequently it is necessary to send in confidential records to HCFA in order to receive payment.

We think this is an egregious situation and you should have—your psychiatric records should be confidential and no government

clerk should have access to them. We hope we will get some action on that.

Mr. MCDERMOTT. That is why I voted against the amendments actually, because I recognized what was in them, read them, and said this isn't going to work in the long run, or it shouldn't work this way in the long run.

Mr. Chairman, unfortunately I have something I must go to. You have been very generous in letting me ask a long series of questions. I would hope that you would note those questions and that, Mr. Chairman, we could submit them to HCFA when they come before us and let them respond to them as a way of seeing if we can't actually do something positive about this rather than just sort of moan about it.

I would like to actually get some action, and maybe if we present it to them in advance, they could look at them and respond for our committee, if that is a reasonable suggestion.

I am very sorry I have to go. I appreciate what you did at lunch in putting your list together. And if you would submit it to the committee for our consideration and let us try and pass it on, I would certainly be willing to work with the Chairman to try and get some answers on the specifics, because that is really what we hope will come out of this.

Chairman CHAMBLISS. Well, thank you for that suggestion. That is exactly what we had talked about earlier today of doing. Once we complete this—and one reason for getting written responses to questions is that we want to be able to compile a list to send to them to be prepared to respond to this set of circumstances or facts when they come before us. Thank you.

Ms. MURRAY. We actually hadn't completed our list.

Chairman CHAMBLISS. Why don't you go ahead and complete your list and we will get it all in the record. Let's go ahead with it.

Mr. VAUGHAN. Yes, sir. Mine are fairly brief and not numerous, to finish the list:

Expedite the processing of provider numbers when the number exists or the ownership of a hospital or organization changes and therefore that number needs to change, or if an existing physician provider moves to another location or works for a different organization, as many physicians now are employed. And that causes a great deal of problem. It used to transpire within a few days; now it is very lengthy. I am not real sure why the change took place, but a lot of organizations now are changing ownership so it has even more profound affect.

Prompt payment from government and private payers. It is a real key issue with any provider, particularly rural hospitals.

Simplify cost reports. Cost reports reimbursement now has not really driven up costs. Again we still submit a quite lengthy and involved cost report which involves quite a bit of work, a lot of interaction with the government getting it finished up.

Secure the Medicaid DSH program for States. That has been an issue that is subject to I am sure a lot of discussion. But in the rural areas, the disproportionate share is very important. My hospital alone—again, we are a 116-bed hospital, but we provide over \$1 million of indigent charity care each month. So, again, that DSH

payments from the State of South Carolina in combination with Federal funds assist us in some level to help offset that, but it is at risk of disappearing. South Carolina lost over \$50 million in the program this year.

Rationalize the geographic system of payment to hospitals. I don't know, again, when the lines were drawn and the system worked out. I think today, though, it needs to be reevaluated. For instance, my new hospital in Georgia is right on the boundary of the wage market for Savannah. So you know we have a high-wage bracket, but we are in a rural area and are paid as such. I am sure that situation exists throughout the country.

I think the advance beneficiary notification needs some clarification. It is very complex. And it goes back to the statement I made about the lab and whether the hospital would be paid or the patient has to pay it. Again it is an extremely difficult piece of legislation for us to deal with. It is pretty much an unknown right now for us to be able to handle it operationally.

Again I'd have to mirror target true fraud and abuse and come down hard. I think everybody agrees on that. It is a blight on our system. Again I don't have the suggestion, how do you pick out that true fraud? But again I think some different ways of enforcing that need to be looked at. I think where there is intent it is pretty obvious, and when it is found out—I think I speak for most of the hospitals I am familiar with—it needs to be dealt with severely. Reward efficient hospitals and organizations and physicians but, again, reward the ones that show a high degree of quality in outcomes.

There are many outcomes measurements out there now with the Joint Commission and also other organizations, and I think efficiency is important, but outcomes and quality of care are the key issue here. Today I can't say that someone that offers high-quality services is rewarded any differently, other than their own self-satisfaction in what they do, than, say, an organization that doesn't. That might ought to be an objective for the long term. That would complete my statements.

Chairman CHAMBLISS. Did we get them all?

Ms. MURRAY. We did. Thank you.

Chairman CHAMBLISS. All right. Dr. Fletcher.

Mr. FLETCHER. I appreciate your testimonies and your list also. And having just come recently from practicing medicine, I know exactly what you are talking about in working with hospitals.

Chairman CHAMBLISS. Before you get started let me—they have just called me to the floor. I have got to go over and participate in a debate that we have got on our defense authorization bill. I hate to run and leave you, but I will leave you in good hands with the vice chairman of the Task Force, Dr. Fletcher.

I want to tell you how much we appreciate your being here. We thank you for your patience. We want to continue the dialogue with you on this issue which I think is extremely important to your profession, but most importantly I think you would agree it is extremely important to patients out there that you care for and we try to look after in this level up here. So thank you all again very much.

Mr. FLETCHER [presiding]. As I was saying, I understand clearly the concerns you have, and I guess I differ with my other colleague that mentioned how do you write regulations without instilling fear. I think that is a very wrong approach. I think, clearly, those folks that are intending to defraud HCFA and the American taxpayer do need to fear that there will be punishment and criminal penalties for that. But the physician that is out there practicing, the nurse that is in the hospital, and the hospital administrators need to be focusing on patient care and quality, not on fear of their payer. And I think that is what is happening.

Whether some of it is warranted or not may be questioned, but I think there is that feeling out there and I think we have done a disservice, because I don't think even, though, when we all have a great deal of complaints about private insurance and we need patient protection—and there is no question about that—but I don't think there is the same fear of other folks that are paying the bills that there is against HCFA.

Let me just say also in light of that, I think regulations can be promulgated to have HCFA and the administrators help assist us to make sure that we are doing the kind of jobs we need. I know they have been helpful in some cases.

I am very concerned that in my own experience—and I would like for you all to comment on this—two things. One, much of the time that we spend now and I spent with my office staff was on just trying to comply with regulations. That took away our attention and our time toward making sure we kept up on the latest in what is available to care for our patients, making sure that we were overseeing the care of our patients; hours in the evening, making sure that we document everything clearly, dot every I and cross every T. So there was a lot of continuing medical education that is focused toward just CPT coding, et cetera, compliance. We set up a compliance board and structure just so, if they did come in, they would be assured or at least more assured that it was our intent to comply. And the very purpose of that was just to make sure that our intent was understood.

How much time do you all spend, would you say, in making sure that you are educated or your staff is educated just to comply with HCFA regulations?

Ms. MURRAY. I will lead off. I know we all have answers to that. At the hospital, we say—I couldn't agree with your comments more. Let me start there. At the hospital, we say that every person should serve the patient or serve someone who serves the patient. And right now—

Mr. FLETCHER. Let me interrupt you right now. Could you tell me how many folks you have in administration versus people that work for you that touch patients?

Ms. MURRAY. It is another very good question, but I don't know that I can add up all the FTEs right now. But I will be happy to answer that question. But I can give you some examples.

Mr. FLETCHER. That would be fine. If you could look back at your numbers and forward that to the committee for entry into the record it would be great.

[The information referred to follows:]

MS. MURRAY'S RESPONSE TO QUESTIONS FROM MR. FLETCHER

I thank you and the Health Task Force for the opportunity May 18, 2000 to provide testimony on behalf of the American Hospital Association and Northwestern Memorial Hospital (NMH) about the burden of Medicare regulations on providers. Your subsequent request of the Office of Management and Budget to review the Medicare Secondary Payment Questionnaire as a possible violation of the Paperwork Reduction Act is much appreciated. This arduous process requires providers to ask beneficiaries up to 25 questions each time they present for a different type of service. A copy of each questionnaire must then be kept (either electronically or on paper) for 10 years.

Below are responses to questions posed during the hearing for which I did not have an immediate answer. I have also included suggestions for change and examples of problems experienced by providers that I hope will be useful to the Committee in future meetings with the Health Care Financing Administration on this issue.

Congressman Fletcher inquired as to the number of NMH employees assigned to patient care activities as opposed to those whose work entails non-patient care activities. Currently at NMH, 3,084 employees provide patient services (e.g. nurses, physicians) while 1,563 employees have non-patient care roles (e.g. housekeeping, food service, billing and accounting, administration, attorneys, facilities management, etc.) for a total of 4,647 employees.

The Congressman also asked about the necessary staff time and expense of complying with Medicare regulations. Six departments handle the bulk of the Medicare compliance and billing: Patient Accounting, Admissions and Registration, Case Management, Medical Records, Information Systems and Corporate Compliance. We estimate these departments (25 FTEs) spend 46,352 hours annually on Medicare compliance. The estimated annual cost of this, including salaries, benefits, equipment, materials and vendor fees, is \$1,590,747. However, this is not a complete estimate of the true annual cost of compliance with existing Medicare regulations. It does not include the work of our legal team, senior management, and the physician relations department, nor does it include the cost of conducting a necessary internal audit to ensure compliance. We are in the process of developing a system to better track the time and money spent in this regard.

My testimony also included an explanation of the difficulties surrounding the requirement that claims for certain lab tests include an ICD9 code diagnosis (inpatient) prior to testing or the claim will be rejected. The catch 22 here is that the diagnosis cannot be made without the test results. Congressman McDermott asked when this requirement became effective. This policy went into effect on January 1, 2000. As I said in my testimony, because of this policy, hospitals are forced to choose between providing the care or delaying the test until the proper diagnostic code is received. NMH chooses to provide the tests and risks not receiving reimbursement. In May I reported to you that NMH was holding \$3 million in Medicare laboratory billing for this reason. This figure has grown to \$4.6 million in just over a month.

In addition to addressing the above issue, other suggestions for change include:

I. Medical necessity standard.

The problem is not with Medicare's expectation that physicians and hospitals provide only medically necessary services to Medicare beneficiaries, it is with the implementation of the standard. HCFA has delegated the responsibility of determining medical necessity to the local fiscal intermediaries. The vehicle for this determination is a publication called the local medical review policy (LMRP). Medical necessity standards or LMRPs should not be "local", they should be implemented nationally and for both Part A and Part B for the reasons listed below:

1. Patients who access services in multiple fiscal intermediary areas find inconsistencies in the benefits covered.
2. Areas serviced by multiple fiscal intermediaries are subject to differing policies.
 - (a) Hospitals (Part A) and Physician Offices (Part B) offering similar services are not subject to the same requirements.
 - (b) Areas where hospitals in close proximity are covered by two different FIs are not subject to the same requirements.
3. Fiscal Intermediaries are not communicating policies (which determine whether benefits are paid) to patients, physicians, or hospitals on a consistent basis.
 - (a) Part A FI does not distribute draft policies to providers or physicians for review and comment; they are distributed to professional organizations, who then distribute them to local providers (not physicians).
 - (b) Part B FI does not distribute new Part A policies to physicians who refer their patients to Part A providers.

(c) Part A FI does not communicate benefit changes (by service area) to beneficiaries.

EXAMPLE

Consider three physicians and their patients, noted as physician A, B, or C. All three physicians' offices are in the same building (different offices) and each orders a chest x-ray for their patient, with the exact same reason for the test.

Physician A orders and performs the chest x-ray in his office.

- No Part B LMRP exists for chest x-ray.
- Physician bills Medicare; claim is paid.

Physician B orders chest x-ray and refers patient to Hospital 1 for test.

- No Part A LMRP exists for chest x-ray
- Hospital bills Medicare; claim is paid.

Physician C orders chest x-ray and refers patient to Hospital 2 for test

- Part A LMRP exists for chest x-ray
- Diagnosis provided does not meet LMRP requirements
- Service considered "non-covered" by Medicare

As a result, Hospital 2 is faced with the following possible scenarios:

1. Prior to rendering care, the hospital explains to the beneficiary the services are not covered by Medicare and the patient either:

- Agrees to sign the Advanced Beneficiary Notification (ABN), which makes the patient responsible for the charges.

• Insists the provider bill Medicare. This requires manual intervention on the part of the hospital to ensure the proper coding is on the claim to indicate the patient's demand for billing, so as not to be included as an example of a "false claim".

2. Hospital 2 is unable to make the determination prior to the provision of care, and therefore is

- Not reimbursed for the service by Medicare and is prohibited from seeking reimbursement from the patient because it did not notify the patient in advance, or
- Able to follow-up with the ordering physician to determine if has "another" reason for ordering the test, but is prohibited from providing information regarding the "acceptable" reasons for ordering the test.

A number of problems exist because of this inconsistency in LMRPs:

BENEFICIARY PERSPECTIVE

1. Covered Medicare benefits are not consistent from provider to provider. A beneficiary could interpret this an unequal access to services among Medicare providers.

2. Medicare patients may interpret these requirements as the hospital trying to limit access to services, thereby preventing him from receiving medically necessary treatment.

3. The beneficiary is not aware prior to the point of service that this very routine test ordered for what appears to be medically necessary reasons (based on his/her discussion with the physician), will not be paid for by Medicare. The patient is placed in the upsetting situation of deciding whether he can or cannot afford to have the test.

PROVIDER PERSPECTIVE

1. This situation impacts the facility's ability to meet community health care needs and impacts the facility's financial viability.

2. Medicare does not save money in this fashion; Medicare pays the same amount from one provider or another.

3. This situation is not ensuring Medicare beneficiaries receive medically necessary services, but rather redirects business from one healthcare facility to another.

4. Providers assume all responsibility for communicating the coverage limitations under the pertinent LMRP to both physicians and patients as neither HCFA nor the fiscal intermediaries do so.

5. Neither the patient nor the physician cares where the patient has the test done; both are approved/certified/licensed facilities. Both the physician and the patient want the test so treatment for the patient's condition can be defined and begun.

6. This situation negatively effects providers' ability to satisfy their patients' healthcare needs.

PHYSICIAN PERSPECTIVE

Though the physician is required to provide coding for services ordered, but performed outside of his practice,

1. The physician has not been notified by Medicare of the requirements
2. The physician has not been provided with the applicable policies associated with the outside referral points
3. The physician's administrative costs are now increased to provide the necessary coded information for each and every test ordered (beyond the single reason for visit to his office).

II. HCFA should work in tandem with major patient accounting systems vendors and hospitals, physicians, independents (e.g., labs, clinics, etc.) to develop a strategic information technology (IT) plan that provides for successful implementation of proposed changes.

Essentially, the problem is that HCFA implements process changes the same way it did 10 years ago despite the automation of today's information technology. A decade ago, HCFA announced changes that were then manually managed by providers from paper documentation. Today the complexity and inter-relatedness of the electronic file layout are substantial and require numerous verifications to assure accuracy. The precise manner in which the electronic file layout has changed is extremely important due to the ramifications to other data.

For instance, when a new code is introduced, it must be determined whether the code is alpha or numeric, where the characters fall in a data line, whether it is a new character set or whether characters are to be reused. Small changes in coding effect numerous "jobs" and reports, all of which must be tested to ensure accuracy and system balancing. However, implementation is invariably rushed because of the schedule set by HCFA, and yet hospitals and other providers are subject to prosecution for fraud and abuse for any errors which occur as a result.

Thus, a comprehensive, strategic IT plan would include:

1. Full disclosure of complete and accurate code/program changes, edits, etc.
 2. Defined testing periods that include fiscal intermediary software development and validation testing, provider development and validation testing, joint validation testing, full production level/parallel testing between the the provider and the FI.
- This would, at its most basic level, require defined periods for each phase of testing that do not exist today. Providers have found that FI's are still in the development stages right up to the point of implementation. Providers are then forced to implement systems that are neither tested, nor functioning properly and thereby require manual change resulting in payment delays at the provider level.

Additionally, because these local medical review policies are implemented in select areas and inconsistently within areas, none of the major systems vendors see this as a federally mandated change. Thus,

1. Vendors are unable to plan, develop, test and implement system solutions to support compliance.
2. Hospitals are unable to implement changes in a timely or efficient manner to support compliance, thereby resulting in high risk for reimbursement losses.

HCFA's response has been that hospitals are reimbursed via the cost report mechanism. However, at its best, the cost report mechanism only realizes 25-30 percent of actual costs (outpatient) and this practice is scheduled for elimination within the next 2 to 3 years.

As a result, hospitals bear the public relations, educational, and financial costs of communicating, educating, implementing, and enforcing these significant changes for beneficiaries and physicians, while the Medicare program itself has assumed little responsibility.

III. The Outpatient PPS implementation should be delayed further due to the fiscal intermediaries inability to test these systems and reimbursement changes with providers or major hospital system vendors.

1. As of today, our fiscal intermediary has not provided test capabilities to any of the hospitals it services in the Chicago area, nor has it tested PPS with any of the major patient accounting software vendors. Thus we anticipate an increase in the number of claims denied, payment delays and other problems. Though we are pleased at the Office of the Inspector General's announcement that OIG will not pursue providers for fraud and abuse during the outpatient PPS implementation, a further delay in the implementation would allow for a smoother, less problematic transition.

2. Medicare has not required Medicare Replacement (e.g. HMOs) or Supplemental carriers to implement these changes. As a result, neither group will be ready to accept the expanded line item billing, nor calculate fees based on the PPS. In addition, Medicare has not been able to define how beneficiaries will manage multiple Explanations of Benefits.

nation of Benefits forms that might be received for rejected line items that are subsequently submitted and processed. Supplemental carriers have informed Medicare of their inability to process these claims.

IV. HCFA should decriminalize billing errors and release information that will enable providers to bill for care more accurately and more efficiently. HCFA should take steps to communicate directly with all providers (e.g., hospitals, physicians, clinics, etc.) of impending changes, with plain English definitions of how these changes will impact their practices in advance of their implementation.

As any billing error in Medicare can be interpreted as a false claim and thus is subject to criminal penalties, hospitals cannot submit many claims for legitimately provided care as they are unable to code and process these claims without risking prosecution for fraud and abuse.

Ms. MURRAY. Let me tell you that the fastest growing segment of our costs is administrative. Despite the fact that we are maintaining our nurse/patient ratios at their historical levels, we are having serious difficulty controlling the growth of our administrative costs, particularly in legal, audit, and outside consultation, utilization management, corporate compliance staff, et cetera.

We have whole new staffs now in place to comply with the new corporate compliance constant issues of fraud and abuse corporate compliance, Federal audits, et cetera. We too have a whole corporate compliance program, committee, et cetera, as I mentioned earlier. Our people who want to either serve a patient or serve someone who serves a patient are now telling me, "But I only get to serve paper, I don't get to serve someone who serves a patient. I have to serve the paper." and that is extremely demoralizing for people who really want to take care of patients.

So my committee, my staff, has just incredibly high hopes that something could be done about this by the testimony at this hearing. I think it is probably not as easy as that. But if there were some way that we could get our focus back on patient care and quality, we should do that.

Mr. FLETCHER. Dr. Robinson.

Dr. ROBINSON. In our situation—well, I will just speak as the country doctor, if I can say that. Actually I try and avoid as much entanglement as possible with these regulations. I try and focus as much as I can on patient care. And so I am a reluctant, I guess I would say, acolyte to the HCFA's regulations, in general, and general paperwork. But in our office we have three employees that are pretty much full-time people devoted to trying to keep the paperwork straight with the—

Mr. FLETCHER. How many physicians do you have?

Dr. ROBINSON. We have five. So three of them are essentially devoted to keeping the HCFA paperwork straight. There are numerous conferences people go to, there are numerous bits of information that have to be looked into. The paperwork that comes my way, there is a big effort on the part of my office to minimize it, but I still have to spend some—I can't tell you the exact time, I will say if I work—maybe a workweek for me might be 60 or 70 hours a week, and maybe 5 to 7 percent of that would be enmeshed in some kind of bureaucratic paperwork, some number like that. So, a significant amount of time and a significant amount of energy trying to keep things straight.

Mr. FLETCHER. Mr. Vaughan.

Mr. VAUGHAN. I would say in the South Carolina hospital that I just served, we have 360 FTE and about 200 or so were nurses

and 100 or so were ancillary involved in the lab or what have you, another 50 that were involved in business functions, and very few in administration per se but involved in the business office and accounting and data processing. And then I would say, of those, the best estimate of those is probably about 15 people are involved in regulatory. That is FTEs. It is spread amongst various people, but that would be full-time equivalents, 40-hour weeks, particularly in a year where you know you have—you are dealing with the Joint Commission survey, as we have just had, and getting totally up with the standards and doing a lot of work and checking yourself.

At any given time, I'd say it is more like 10 FTEs, which may not sound like a significant percentage, it is like 3.6 percent, but for a smaller hospital when there is really not a lot of support staff, as I mentioned earlier, it falls on the shoulders of clinical people.

For instance my lab director with a new lab regulation as I just mentioned, I recall how hard it was for her to put the software into the system and deal with the coding, you know, which is almost a completely different type of thing to use. And then I have got the physicians, on the other hand, talking to me about how they comply and remain compliant when they don't know what the patient has, that is why they are ordering the lab tests. You can see the frustration on everybody's part.

At least speaking for small hospitals, we don't have as many staff so the biggest problem is it falls on clinical people's time and again takes away from things you would rather have them doing; checking the laboratory as that director, as she should, you know, for the clinical functions and staffing. And all my directors are working directors. I don't have a single director in any hospital that doesn't staff and take a position on the floor or at a piece of equipment. They back off and take care of administrative duties as well.

But again, it is not so much that, and I don't feel that, again, the things that everyone is trying to achieve are not important, they all are; it is just the method. And maybe more so the understanding of the day-to-day functions of a doctor's office, a large hospital—or even a small hospital or nursing home, it appears to me, and it has over the years—I am not trying to be critical, but it doesn't seem, the regulations don't come down with a great deal of knowledge of what the work flow is really like. In other words, they are not practical. I think everybody agrees on the intent.

Hospitals I can speak for go to great lengths to comply and really, as I say, look down on anyone that is not. If you look out there, I think the bad reputation is again on a few. But everyone now is burdened significantly by the few that really have gotten us into this framework within the regulations. But there is probably more tension on a small hospital.

Mr. FLETCHER. Well, thank you all for your testimonies. I think you know, I clearly know, we all share the concern that we don't want dollars wasted and especially wasted on individuals or entities that clearly have the intent to defraud HCFA and the taxpayers. And so I think we all want very good efforts to make sure that the bad players are identified, that they are stopped and they are penalized, so that there is certainly a deterrent for that kind of action. So I think, you know, among the colleagues I have

worked with, most of the providers, an overwhelming proportion of the providers want to do a good job, are not out there to increase their billings unlawfully, but it becomes very difficult.

And let me ask Dr. Robinson one more question, then we are going to close out the hearing, and that is the problem that I found to be frequent was the fact that there are so many requirements on the specifics of documentation for a particular code that sometimes you tend even not to code things. You downcode, actually, is what we found when we reviewed many of our charts, because of the fear of overcoding and because of documentation. Just share with me a little bit of your concern on that personally, if you could.

Dr. ROBINSON. Well I will throw out maybe one or two examples. Some years ago, when the initial coding regulations were promulgated by HCFA in regards to office visits, as to how you would code those, it would be a complicated visit or not a complicated visit we, were totally befuddled about the correct thing to do, so we just basically elected to make everything the same. So we downcoded everything, and in fact then we were told this would be a terrible mistake, we would be audited, and we were forced to upcode. But we are still very nervous about it.

So the tendency is always to downcode. I mean, the thrust of every doctor I know of is to just avoid any kind of conflict with HCFA and to never do anything that is inflammatory. And if there is any dispute we would downcode.

One story involves a neurology group in my town who are very reputable, diligent, splendid physicians who do a good job. And they had a series of patients that they all undercoded upon. And there is a reason for it. They just felt that was the right thing to do. These patients were essentially extended care patients in a nursing home environment. But in any event, they put—all their codes were put in as the lowest possible code.

Then what happened was—they fell out of—the HCFA computer picked them up as undercoders. So out of the blue, the black helicopters arrived and they swooped in and they went through a pretty extraordinary ordeal. The reviewers came in and took random charts and they found documentation—there were documentation disputes about this. And these neurologists are very reputable, very compulsive, very uptight people. This was very upsetting experience for them. They retained an attorney, they got an accountant in there. They had numerous meetings, lost sleep, and this process went on for months. And they counteracted the accusations that the documentation wasn't correct, and there was back and forth.

The process went along for about 10 months. They then had a quick visit, they gave their—they gave their report, and they are still in limbo. So it hasn't been as if this process has been easily terminated. They said the difficulty that happened was that we made the mistake of undercoding. And if we had only charged the government more money, we would have been spared this ordeal.

And so that is—those are just some vignettes about that.

Mr. FLETCHER. Thank you all. I think it is time that we probably adjourn the hearing. Your testimony I think has been very informative. We are going to continue these hearings and hopefully hear from HCFA. I do think, whether it is the folks that work for HCFA as well as providers, I think everyone has the same intent, and

that is to make sure we get good patient care, good quality. But obviously from what we have learned today, I think in the implementation of that there is a lot of room for improvement.

So we look forward to holding these hearings and continue to hold the hearings and be able to provide a lot of information. Your testimony has been very beneficial. And we thank you for coming today. And this meeting is adjourned. Thank you.

[Whereupon, at 2:12 p.m., the Task Force was adjourned.]